

In the Matter Of:

*KELLI DENISE GOODE vs
CITY OF SOUTHAVEN
3:17-cv-060-DMB-RP*

*GARY VILKE
December 08, 2017*



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EXHIBIT 1

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<p>1 The videotaped deposition of GARY VILKE, 2 M.D., is taken on this, the 8th day of December, 3 2017, on behalf of the Plaintiff, pursuant to 4 notice and consent of counsel, beginning at 5 approximately 8:02 a.m. in the offices of Peterson 6 Reporting Video and Litigation Services, 530 B 7 Street, Suite 350, San Diego, California. 8 This deposition is taken pursuant to the 9 terms and provisions of the Federal Rules of Civil 10 Procedure. 11 All forms and formalities are waived. 12 Objections are reserved, except as to the form of 13 the question, to be disposed of at or before the 14 hearing. 15 The signature of the witness is waived. 16 17 18 19 20 21 22 23 24</p>	<p style="text-align: right;">2</p> <p>1 A P P E A R A N C E S 2 FOR THE PLAINTIFF: (TELECONFERENCE APPEARANCE) TIM EDWARDS, ESQ. 3 KEVIN McCORMACK, ESQ. Ballin, Ballin & Fishman 4 200 Jefferson Avenue Suite 1250 5 Memphis, Tennessee 38103 901-525-6278 6 TELEPHONIC APPEARANCE: 7 JAMES F. GARRETT, ESQ. Eastland & Garrett, PLLC 8 103 North Lamar Blvd. Suite 204 9 Oxford, Mississippi 38655 10 FOR THE DEFENDANT, DR. DONJA OLIVER: MARTY R. PHILLIPS, ESQ. 11 Rainey, Kizer, Reviere & Bell, PLC 12 50 North Front Suite 610 13 Memphis, Tennessee 38103 901-333-8101 14 APPEARING VIA TELEPHONE: 15 J. RIC GASS, ESQ Gass Weber Mullins, LLC 16 309 N. Water Street Milwaukee, Wisconsin 53202 414-224-7697 17 TELEPHONIC APPEARANCES 18 FOR THE DEFENDANTS, THE CITY OF SOUTHAVEN AND 19 INDIVIDUAL SOUTHAVEN DEFENDANTS: 20 BERKLEY N. HUSKISON, ESQ. Mitchell, McNutt & Sams, P.A. 21 105 South Front Street Tupelo, Mississippi 38804 662-620-6260 22 23 24</p>
<p>1 FOR THE DEFENDANT, BAPTIST MEMORIAL HOSPITAL- DESOTO: 2 DAVID UPCHURCH, ESQ. Upchurch & Upchurch, P.A. 3 141 S. Commerce Street Suite B 4 Tupelo, Mississippi 38804 662-260-6953 5 FOR THE DEFENDANT, SOUTHEASTERN EMERGENCY 6 PHYSICIANS, INC.: MATTHEW R. MACAW, ESQ. 7 McDonald Kuhn, PLLC 5400 Poplar Avenue 8 Suite 330 Memphis, Tennessee 38119 9 901-526-0606 10 11 ALSO PRESENT: JAVAN HEARD, VIDEOGRAPHER 12 13 14 15 16 17 18 19 20 21 COURT REPORTING FIRM: PETERSON REPORTING VIDEO & LITIGATION 22 Bobbie Hibbler, CSR, 12475, LCR 029 530 B Street, Suite 350 23 San Diego, California 92101 619-260-1069 24</p>	<p style="text-align: right;">4</p> <p>1 EXAMINATION INDEX 2 3 GARY VILKE, M.D. BY MR. EDWARDS 9 4 BY MR. HUSKISON. 232 FURTHER BY MR. EDWARDS 233 5 6 7 EXHIBIT INDEX 8 EXHIBIT DESCRIPTION PAGE 9 EXHIBIT NO. 1 NOTICE OF DEPOSITION 8 10 EXHIBIT NO. 2 ORDER FROM JUDGE PHAM 47 11 EXHIBIT NO. 3 BLACK BOX INFORMATION FOR HALOPERIDOL 74 12 EXHIBIT NO. 4 UNRECOGNIZED HYPOXIA AND 13 RESPIRATORY DEPRESSION 75 IN EMERGENCY DEPARTMENT 14 PATIENTS SEDATED FOR PSYCHOMOTOR AGITATION 15 EXHIBIT NO. 5 LETTER DATED 1/21/01 87 16 EXHIBIT NO. 6 (WILL BE PROVIDED) 17 EXHIBIT NO. 7 BOOK ENTITLED GUIDELINES FOR 98 18 INVESTIGATING OFFICER- INVOLVED SHOOTINGS, 19 ARREST-RELATED DEATHS, AND DEATHS IN CUSTODY (NOT ATTACHED) 20 21 EXHIBIT NO. 8 ATIVAN (LORAZEPAM) INJECTION 116 22 EXHIBIT NO. 9 PERCEPTIONS OF SUPPORTED AND 117 PRONE- 117 23 RESTRAINT POSITIONS 24</p>
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<p>8 1 WHEREUPON, EXHIBIT NO. 1 WAS PREMARKED 2 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED 3 HERETO.) 4 5 THE VIDEOGRAPHER: Good morning. 6 Today's date is December 8, 2017. The time is 7 approximately 8:02 a.m. The location is 530 B 8 Street, Suite 350, San Diego, California 92101. 9 This Case Number is 3:17-cv-060-DMB-RP. The file 10 is in the United States District Court for the 11 Northern District of Mississippi in the case of 12 Kelli Denise Goode versus the City of Southaven, 13 et al. 14 The deponent today is Dr. Gary 15 Vilke. Counsel and all present please identify 16 yourselves for the record. 17 MR. EDWARDS: Tim Edwards and Kevin 18 McCormack for Mrs. Goode. 19 MR. GARRETT: Jim Garrett also for 20 Mrs. Goode. 21 MR. PHILLIPS: I'm Marty Phillips here 22 for Dr. Oliver along with Ric Gass. 23 MR. MACAW: Matt Macaw for Southeastern 24 Emergency Physicians, LLC.</p>	<p>9 1 MR. HUSKISON: Berkley Huskison 2 telephonically for the Southaven defendants. 3 THE VIDEOGRAPHER: The court reporter 4 may now swear in or affirm the deponent. 5 GARY VILKE, M.D., 6 Having been first duly sworn, was examined and 7 testified as follows: 8 EXAMINATION 9 BY MR. EDWARDS: 10 Q. Doctor, I am Tim Edwards. Would you 11 state your name please? 12 A. Gary Michael Vilke. 13 Q. And, Doctor, you are a resident of San 14 Diego County, California; correct? 15 A. Yes. 16 Q. You have been disclosed as an expert by 17 a number of the defendants in this case. Are you 18 aware of that? 19 A. I know I've worked with counsel for 20 Dr. Oliver as an expert. I'm not sure who else 21 has disclosed me as their expert. 22 Q. Well, you have been adopted by reference 23 by all of the defendants I believe. Were you 24 aware of that?</p>

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<p>1 A. I can't say I'm specifically aware of 2 it. No. 3 Q. All right, Doctor. You have given a 4 number of depositions; correct? 5 A. Yes. 6 Q. Actually you have testified in defense 7 of police departments who have had in custody in 8 restraint deaths from the East Coast to the West 9 Coast; correct? 10 A. I have had cases on both coasts. Yes. 11 Q. And places in between? 12 A. Correct. 13 Q. You are the go-to guy in the United 14 States for hogtied deaths; correct? 15 A. I have done a lot of research in the 16 area and have been asked to testify many times. 17 Q. For police departments? 18 A. Police departments have retained me or 19 their counsel. Yes. 20 Q. Yeah. But not -- you've not testified 21 for any plaintiffs? 22 A. I think I testified a long time ago for 23 a plaintiff. 24 Q. Was that before your 1997 study?</p>	<p>11 1 A. I believe it was shortly thereafter. 2 Q. You are not a forensic pathologist, are 3 you? 4 A. I am not. 5 Q. And you have been proffered in the case 6 to give an opinion on the cause of death of Troy 7 Goode; correct? 8 A. Correct. 9 Q. You've never performed an autopsy? 10 A. Correct. 11 Q. Your opinion is that Mr. Goode died of 12 what you term excited delirium syndrome; correct? 13 A. Cardiac arrest due to excited delirium 14 syndrome because of his LSD use. Yes. 15 Q. Well, excited delirium syndrome is a 16 controversial concept within the field of 17 medicine; correct? 18 A. There have been some controversies 19 within the field about that. Yes. 20 Q. Excited delirium is not uniformly 21 accepted by medical specialties as a valid 22 condition; correct? 23 A. It's been accepted by specialties that 24 take care of patients in excited delirium. But</p>
<p>12 1 you wouldn't expect dermatologists or 2 endocrinologists to recognize what that is. 3 Q. Has it been accepted by cardiologists? 4 A. I know cardiologists who have. I don't 5 believe it's ever gone and been requested to be 6 accepted by their national organization. 7 Q. So the answer is no, the national 8 organization of cardiologists does not recognize 9 excited delirium? 10 A. That's a question I don't know. I don't 11 know that I've been ever asked to answer that 12 question. 13 Q. Excited delirium is a concept which is 14 heavily involved, if you will, with the 15 functioning of the heart of people under certain 16 stressors; is that correct? 17 A. The heart is involved in excited 18 delirium. Yes. 19 Q. And your opinion is that Mr. Goode died 20 of excited delirium precipitated by LSD use and 21 resulting in cardiac arrest? 22 A. That's a fair assessment. Yes. 23 Q. That means his heart gave out? 24 A. It went into a dysrhythmia and stopped</p>	<p>13 1 beating correctly. 2 Q. His heart gave out; correct? 3 A. It would be a lay term for it. But the 4 reality is the electrical activity is defective. 5 Q. Well, you do understand I am a 6 layperson, so I might not use correct medical 7 terms; correct? 8 A. That's possible. Sure. 9 Q. All right. You have noted in some of 10 your testimony that you are aware of Dr. DiMaio 11 who was the medical examiner for the County of 12 Bexar, San Antonio, Texas; right? 13 A. I know he's a medical examiner in Texas. 14 I wasn't sure specifically what area. 15 Q. He is a board certified forensic 16 pathologist; right? 17 A. I don't know if he has board 18 certification in there. I know at one point he 19 was. 20 Q. Forensic pathologists are the ones who 21 determine cause of death through autopsy; right? 22 A. They're the ones who perform the 23 autopsies and they do perform -- identify cause of 24 death. Yes.</p>

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<p style="text-align: right;">14</p> <p>1 Q. And when a forensic pathologist can't 2 find a cause of death of a person who died under 3 the influence of drugs and in restraints put on by 4 the police, the default position is excited 5 delirium; correct?</p> <p>6 A. I have never heard that be a default 7 position.</p> <p>8 Q. That's where forensic pathologists who 9 believe in the concept of excited delirium go to 10 with cause of death when they can't find any other 11 when a person in police restraints dies under the 12 influence of a drug?</p> <p>13 A. They have to have certain symptoms and 14 criteria that would meet the classification for 15 excited delirium syndrome. They don't have to be 16 in restraints. They don't have to be in police 17 custody. But if the findings and the presentation 18 is consistent with excited delirium syndrome and 19 there is no obvious other source of death like a 20 brain hemorrhage or a blood clot, they often will 21 use that as a diagnosis to identify the cause of 22 death.</p> <p>23 Q. And if they find three or more markers 24 of excited delirium in your opinion, is that</p>	<p style="text-align: right;">15</p> <p>1 sufficient to designate the cause of death as 2 excited delirium?</p> <p>3 A. Again, you sort of have to look at the 4 entire picture, the presentation. Typically 5 there's more than three markers. If you're going 6 to identify a specific markers, usually there's, 7 you know, five or so. But there is no 8 identifiable specific number that would define 9 excited delirium. A lot of it is the clinical 10 presentation, the presence of drugs in the system, 11 the way they behave and act, and the lack of other 12 causes of sudden death. If they have sky high 13 potassium levels, then the cause of death is 14 probably hyperkalemic cardiac arrest. But you 15 have to look at the whole picture.</p> <p>16 Q. But you do recognize certain markers 17 that indicate excited delirium; right?</p> <p>18 A. There are a characteristics that are 19 consistent with the diagnosis of excited delirium 20 syndrome. Yes.</p> <p>21 Q. Fair enough, characteristics. You 22 recognize certain characteristics as being 23 indicative of excited delirium?</p> <p>24 A. They are looked for, and if they're</p>
<p style="text-align: right;">16</p> <p>1 present can be consistent with that diagnosis.</p> <p>2 Q. Now Dr. DiMaio in San Antonio has 3 written books on excited delirium syndrome, you're 4 aware of that?</p> <p>5 A. I know he's written at least one. I'm 6 not sure about several books. He's written on 7 chapters as well.</p> <p>8 Q. Dr. DiMaio in his book on excited 9 delirium says that when a forensic pathologist 10 concludes that the cause of death is excited 11 delirium, that's what should go into the autopsy 12 report, specifically death due to excited delirium 13 secondarily struggle or whatever; correct?</p> <p>14 A. You know, I haven't read his book in a 15 long time. So I couldn't say exactly what he put 16 in there.</p> <p>17 Q. So you don't know?</p> <p>18 A. I don't know what he said in that book, 19 no on that topic.</p> <p>20 Q. And you do know that Dr. Barnhart who 21 was the forensic pathologist on this case -- do 22 you know that?</p> <p>23 A. That is correct. Yes.</p> <p>24 Q. Okay. And you know that Dr. Barnhart</p>	<p style="text-align: right;">17</p> <p>1 listed complications of LSD as a cause of death; 2 right?</p> <p>3 A. That is correct.</p> <p>4 Q. Where could you direct me to an 5 authoritative reliable medical text that list 6 complications of LSD as a cause of death?</p> <p>7 A. Complications of LSD certainly can kill 8 people.</p> <p>9 Q. That's not what I asked, Doctor. I 10 asked where could you direct me to an 11 authoritative reliable text that lists 12 complications of LSD as a cause of death?</p> <p>13 A. The ACEP White Paper talks about excited 14 delirium syndrome causing death and also 15 associated with LSD as one.</p> <p>16 Q. The ACEP White Paper?</p> <p>17 A. Correct.</p> <p>18 Q. That's the one you wrote?</p> <p>19 A. That's the one I participated with it 20 with an expert panel. Yes.</p> <p>21 Q. Other than the one, the ACEP White Paper 22 that you wrote, point me to an authoritative 23 reliable medical text that list complications of 24 LSD as a cause of death?</p>

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<p>1 A. I didn't research specifically for 2 complications of LSD. I know that it can cause 3 people to do things to kill themselves. I 4 reviewed articles on that. But if you're looking 5 for a textbook that says those exact words, I 6 don't know if it's if there or I just haven't 7 looked for it yet.</p> <p>8 Q. So your answer is you don't -- you can't 9 point me to an authoritative reliable text that 10 list complications, in quotes, of LSD as a cause 11 of death; correct?</p> <p>12 A. That is correct.</p> <p>13 Q. All right. Now can you -- have you done 14 in research in LSD?</p> <p>15 A. I've haven't done specific research. 16 You mean, looking at the drug itself?</p> <p>17 Q. Yes.</p> <p>18 A. Then no.</p> <p>19 Q. You're not a pharmacologist either, are 20 you?</p> <p>21 A. I am not. No.</p> <p>22 Q. You can't give a toxic level of LSD, can 23 you?</p> <p>24 A. LSD itself is to be -- thought to be one</p>	<p>19</p> <p>1 of the safer drugs as far as true pure overdose. 2 But it can cause behaviors and activities that 3 lead to death.</p> <p>4 Q. Well, that's not what we have here, is 5 it, with Mr. Goode? We don't have him jumping out 6 of a window, for instance, or are off a bridge or 7 some other, or killing himself? We don't have 8 that sort of secondary cause of death secondary to 9 the LSD, do we?</p> <p>10 A. Well, the LSD will cause acidosis. The 11 LSD caused him to hallucinate and be delirious 12 causing him to resist and struggle and fight and 13 be combative. And that agitation that resistance 14 in that continued fighting caused more acidosis 15 which would lead to the sudden cardiac arrest.</p> <p>16 Q. Now, Doctor, you know what, you 17 testified in a case in Nashville I believe where 18 you said that the hogtie restraint reduced oxygen 19 consumption and therefore was beneficial to 20 somebody in a state of excited delirium, did you 21 not?</p> <p>22 A. That sounds something familiar that I 23 would say. Sure.</p> <p>24 Q. So what you're saying now is</p>
<p>20</p> <p>1 diametrically opposed to what you said in the case 2 in Nashville?</p> <p>3 A. I don't agree with that.</p> <p>4 Q. Why don't you? You said that if 5 somebody is hogtied and they can't move their 6 major muscles, then they're their oxygen 7 consumption would go down and that would be 8 beneficial in calming -- in bringing in more 9 oxygen safeguarding the subject; correct?</p> <p>10 A. Sure. It was protective of Mr. Goode, 11 the position was decreasing his oxygen demand. 12 And it was keeping him from using his large 13 muscles, but he kept resisting and kept 14 struggling, and that was continuing to cause 15 acidosis. It was less than he would have had had 16 he been using the big muscle groups by moving them 17 more freely. But his agitation and his consistent 18 the struggling and his consistent yelling was all 19 building up more lactic acid. So the position was 20 the best to help him. But unfortunately he kept 21 fighting against it because of the drugs.</p> <p>22 Q. How did he -- do you agree that 23 Mr. Goode was hogtied?</p> <p>24 A. That's how I understand it, the hands</p>	<p>21</p> <p>1 and the feet were pulled together behind his back.</p> <p>2 Q. No question about that; right?</p> <p>3 A. That's the position I'm operating under 4 as far as what I assume he was in.</p> <p>5 Q. And you have defined in your works the 6 hogtie position is having hands bound behind the 7 back, feet bound, knees bent up, and the hands and 8 feet connected by a chain; right?</p> <p>9 A. Connected by something. Yes.</p> <p>10 Q. And what was the distance between 11 Mr. Goode's hands and feet when he was hogtied?</p> <p>12 A. As I understand it, it was probably six 13 to eight inches, something along those range. 14 Maybe a little bit more, maybe a little less.</p> <p>15 Q. Marijuana played no part in Mr. Goode's 16 death; agreed?</p> <p>17 A. I wouldn't opine that it did. No.</p> <p>18 Q. Did you say that Mr. Goode's death was 19 sudden?</p> <p>20 A. Did I say it was sudden?</p> <p>21 Q. Yes.</p> <p>22 A. His cardiac arrest was sudden. Yes.</p> <p>23 Q. Define sudden death? How do you define 24 sudden death?</p>

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<p>22</p> <p>1 A. Basically the heart goes into an</p> <p>2 irregular beat and a sudden change in physiology,</p> <p>3 the person goes unconscious, has a few agonal</p> <p>4 respirations, and then is, I guess, dead at that</p> <p>5 point and resuscitated.</p> <p>6 Q. Now when did his heart go into an</p> <p>7 irregular beat?</p> <p>8 A. Around the time where the officer noted</p> <p>9 that he had calmed down and looked and saw that he</p> <p>10 had turned blue, just prior to that.</p> <p>11 Q. How do you know?</p> <p>12 A. Because up to that point he was verbal</p> <p>13 and saying things and still moving, and then he</p> <p>14 became quiet. And then -- all the cadence of that</p> <p>15 evaluation basically was within a minute or so.</p> <p>16 Q. How do you know?</p> <p>17 A. Based on the testimony.</p> <p>18 Q. Based solely upon the testimony of a</p> <p>19 defendant police officer; correct?</p> <p>20 A. Based on the police officer's reporting,</p> <p>21 sure.</p> <p>22 Q. With a police officer with no medical</p> <p>23 training; correct?</p> <p>24 A. I don't know the background of his</p>	<p>23</p> <p>1 medical training. They usually have some basic</p> <p>2 life support training. But I don't know the</p> <p>3 specifics of this officer.</p> <p>4 Q. You don't know what happened in the last</p> <p>5 ten minutes of Troy Goode's life, do you, other</p> <p>6 than what the police officer said?</p> <p>7 A. If you're asking if I was in the room,</p> <p>8 no. As I understand though that he was yelling</p> <p>9 and making noises, and those types of things were</p> <p>10 being reported.</p> <p>11 Q. Doctor, we can agree that you weren't in</p> <p>12 the room. My question, so you don't have to</p> <p>13 qualify your answer with that, you can simply say</p> <p>14 the only way -- the only information you have is</p> <p>15 from Officer bag begin; correct?</p> <p>16 A. I believe there was a witness in the</p> <p>17 other room that said he was making noises as well</p> <p>18 from across the hall. So that's somebody else</p> <p>19 saying that he was verbalizing something. But the</p> <p>20 most of the work is from Officer Baggett as far as</p> <p>21 what I understand.</p> <p>22 Q. What witness are you referring to in the</p> <p>23 other room?</p> <p>24 A. I'd have to look her name up. She was</p>
<p>24</p> <p>1 deposited by -- Janet Tharpe.</p> <p>2 Q. And she said -- tell us what your</p> <p>3 interpretation of Ms. Tharpe's testimony is?</p> <p>4 A. She was saying that she was hearing some</p> <p>5 moaning and some noises that were loud from across</p> <p>6 the hall that she thought were from Mr. Goode.</p> <p>7 Q. She said she was hearing someone yell</p> <p>8 breathe; correct?</p> <p>9 A. She heard the word breathe as well. But</p> <p>10 she also reflected that she heard some moaning</p> <p>11 going on that was very loud.</p> <p>12 Q. What did she see when Mr. Goode was</p> <p>13 passed on the gurney within inches of her?</p> <p>14 A. I'm not sure about inches. But he was</p> <p>15 alive and had a very red face apparently and his</p> <p>16 eyes look like they were bugging out.</p> <p>17 Q. And was incapable of movement; correct?</p> <p>18 A. Her report that he was unable to move is</p> <p>19 in a position that look like he couldn't move.</p> <p>20 Q. Sir, I didn't understand that.</p> <p>21 A. She reported that he appeared to be in a</p> <p>22 position where he couldn't move.</p> <p>23 Q. Well, you know from all of your work of</p> <p>24 hogtying, if you're hogtied you're not going to be</p>	<p>25</p> <p>1 doing much movement, are you?</p> <p>2 A. I disagree with that as well. People</p> <p>3 can roll gurneys over and hogtied and flip over</p> <p>4 and turn if they are so in desire of doing that</p> <p>5 and under the influence of drugs. So they can</p> <p>6 certainly move around a lot. They just can't do a</p> <p>7 lot of flexion and extension of the large muscle</p> <p>8 groups.</p> <p>9 Q. So your testimony is you've known people</p> <p>10 turn over gurneys who were hogtied and represented</p> <p>11 a threat to others?</p> <p>12 A. There's a compound question there. But</p> <p>13 I have known people to flip gurneys over who have</p> <p>14 been restrained. I have also had people get hurt</p> <p>15 by head butting and flipping and stuff like that</p> <p>16 while they're hogtied, sure.</p> <p>17 Q. You -- well, strike that. You have used</p> <p>18 -- can you refer us to any authoritative reliable</p> <p>19 medical text that says that LSD causes death?</p> <p>20 A. If you're asking about in and of itself</p> <p>21 just use of it as a toxic medication -- or drug, I</p> <p>22 don't believe it cause it by itself. But the</p> <p>23 behaviors created by LSD as we talked about</p> <p>24 earlier has been published and caused people to do</p>

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<p style="text-align: right;">26</p> <p>1 things that end up dying.</p> <p>2 Q. Well, we'll talk about this more. But</p> <p>3 tell the jury what drugs are commonly associated</p> <p>4 with excited delirium?</p> <p>5 A. Sure. If you look at the literature</p> <p>6 they refer to cocaine, methamphetamine, PCP.</p> <p>7 There's some data about bath salts now that seems</p> <p>8 to be out there. And LSD is listed as well.</p> <p>9 Q. LSD is virtually unseen in the</p> <p>10 literature, isn't it?</p> <p>11 A. Virtually unseen in the literature</p> <p>12 under --</p> <p>13 Q. In the context of excited delirium?</p> <p>14 A. It is not as common as cocaine and</p> <p>15 methamphetamine.</p> <p>16 Q. Not as common. Cocaine and amphetamine</p> <p>17 account for 99.9 percent of excited delirium</p> <p>18 situations; correct?</p> <p>19 A. I don't know about that number. But</p> <p>20 it's certainly a strong majority of those two</p> <p>21 drugs, yeah.</p> <p>22 Q. You have written that early intervention</p> <p>23 is the best approach to avoiding death in a person</p> <p>24 who is in excited delirium due to drug</p>	<p style="text-align: right;">27</p> <p>1 intoxication; correct?</p> <p>2 A. Early intervention is the best way to</p> <p>3 try to avoid sudden death. It doesn't necessarily</p> <p>4 prevent it.</p> <p>5 Q. Well, and you've also written that the</p> <p>6 people who have the opportunity for the earliest</p> <p>7 intervention are the EMTs particularly; right?</p> <p>8 A. They often are the first ones to have a</p> <p>9 medical contact with the patient.</p> <p>10 Q. And they were in this case?</p> <p>11 A. The EMTs were involved in this case.</p> <p>12 Yes.</p> <p>13 Q. And when the EMTs arrived on the scene</p> <p>14 what was Mr. Goode's status?</p> <p>15 A. I believe he was -- actually I don't</p> <p>16 remember still if he was restrained at that point</p> <p>17 or not. But he was agitated, violent, combative.</p> <p>18 And I don't remember if the police actually</p> <p>19 already had him restrained or not at the time of</p> <p>20 their arrival.</p> <p>21 Q. Mr. Goode was no threat to anyone when</p> <p>22 the EMTs arrived; correct?</p> <p>23 A. Just to answer the question I don't</p> <p>24 remember the exact status. But if he was</p>
<p style="text-align: right;">28</p> <p>1 restrained, he was certainly less of a threat than</p> <p>2 if he wasn't restrained.</p> <p>3 Q. Well, if the police officers on the</p> <p>4 scene said that he was secure and represented no</p> <p>5 threat, you have no information to the contrary to</p> <p>6 that, do you?</p> <p>7 A. Anybody can be a threat if you're not</p> <p>8 careful around them. But if he is restrained,</p> <p>9 then he would be less of a threat than if he was</p> <p>10 not restrained.</p> <p>11 Q. Doctor, if the police said that Troy</p> <p>12 Goode was no threat by the time the EMTs got</p> <p>13 there, do you have any information to contradict</p> <p>14 that?</p> <p>15 A. Zero threat, I think there is no patient</p> <p>16 that is zero threat, that's what I'm trying to get</p> <p>17 at. If he was restrained then he was a less of a</p> <p>18 threat than if he was not restrained.</p> <p>19 Q. You have also written that a patient in</p> <p>20 an agitated state should have a heart rate monitor</p> <p>21 placed; right?</p> <p>22 A. When feasible, sure.</p> <p>23 Q. Well, it was feasible in this case,</p> <p>24 wasn't it?</p>	<p style="text-align: right;">29</p> <p>1 A. There was a point where it could be put</p> <p>2 on, sure.</p> <p>3 Q. And you've also written that a patient</p> <p>4 in delirium should have constant pulse oximetry;</p> <p>5 correct?</p> <p>6 A. When feasible, sure.</p> <p>7 Q. Well, pulse oximetry was done in this</p> <p>8 case; right?</p> <p>9 A. It was attempted. Yes.</p> <p>10 Q. No. It was -- there was an assessment</p> <p>11 at the scene by Richard Weatherford. Are you</p> <p>12 aware of that?</p> <p>13 A. There was a scene assessment, sure.</p> <p>14 Q. And are you aware that Mr. Weatherford</p> <p>15 did not record the pulse oximetry that he took?</p> <p>16 A. I did not see a pulse oximetry reading</p> <p>17 in the pre-hospital record.</p> <p>18 Q. If you do vitals testing you're suppose</p> <p>19 to record the results; right?</p> <p>20 A. If the vital sign testing appears to be</p> <p>21 reliable I would record them. If it seems to be</p> <p>22 inconsistent or not functioning correctly, I would</p> <p>23 not record them.</p> <p>24 Q. Oh, I see. So if you've got a pulse</p>

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<p style="text-align: right;">30</p> <p>1 oximetry reading and you determine that it was not 2 reliable, you just ignore it; is that what you're 3 saying? 4 A. No. 5 Q. What you would do for good medicine is 6 get another reading, wouldn't you, to see if you 7 can replicate the result? 8 A. If feasible you can, yes. These 9 patients are often so agitated or so moving or 10 cramped up with the hands with the cuffs that it's 11 virtually impossible to get a pulse ox reading. 12 And so if you're getting numbers that are very 13 inconsistent, then there would be no reason to 14 report them because they're not accurate. 15 Q. Yes, if you get multiple numbers that 16 are inconsistent; right? 17 A. Or multiple numbers -- you're putting 18 the pulse ox on and you're getting multiple reads 19 over time. You don't have to keep taking it off 20 and putting it on to actually check to see if it's 21 reliable. 22 Q. Fine. Was that done? 23 A. I don't know. 24 Q. It should have been done; correct?</p>	<p style="text-align: right;">31</p> <p>1 A. It is something you try to do when the 2 person is in the position to be monitored. But if 3 they're still struggling and rolling and spinning, 4 there is no utility of trying to hook up wires and 5 monitors because they just keep falling off give 6 you either artifact or unreliable numbers. 7 Q. What is your understanding of the size 8 of Mr. Goode? 9 A. I believe he was six foot, roughly 170 10 pounds. 11 Q. Actually he was closer to 150 on his 12 driver's license. One seventy was postmortem; 13 correct? 14 A. Which probably is a more accurate 15 weight, but yes. 16 Q. He was bloated? He was full of fluid? 17 A. People don't typically gain weight after 18 death. Their body weight is their body weight. 19 Q. And how many officers were on the scene? 20 A. I am not exactly sure. I know there 21 were at least three, but I don't remember the 22 exact number. 23 Q. How many medics were on the scene? 24 A. Same answer, I'm not a hundred percent</p>
<p style="text-align: right;">32</p> <p>1 sure how many medics were on the scene. At least 2 two, but I don't know. 3 Q. Well, assume that there were only 4 five -- actually, there were more like eight. But 5 are you saying with that manpower present that a 6 pulse oximetry could not be obtained? 7 A. I'm saying that people in this state are 8 often very difficult to have monitors placed and 9 maintained at any functioning status because of 10 movement and artifact. 11 Q. Well, if that's the case then you've 12 also written that the thing to do is to quickly 13 medicate; right? 14 A. That is one of the things we recommend 15 doing for patients who are recognized as being in 16 this state. 17 Q. Right. So what you do is you use 18 chemical restraints to calm the patient down; 19 right? 20 A. Sedating medication, sure. It's 21 semantics. 22 Q. Well, no it's not semantics. The center 23 says that any drugs administered to effect 24 behavioral changes is a chemical restraint, you</p>	<p style="text-align: right;">33</p> <p>1 know that? 2 A. There are different levels of chemical 3 restraint which is why I try to differentiate 4 paralytics or chemical restraint that are used 5 often by trauma surgeons. That would not be 6 appropriate in this type of case. So when I'm 7 using the word -- if you're using the words 8 chemical restraints to reflect benzodiazepines or 9 anti-psychotics to calm somebody, I'm happy to use 10 that term. 11 Q. No. I was using the Center for Medicaid 12 Services. You are aware of that organization, 13 aren't you? 14 A. I've heard of them. Yes. 15 Q. You know it's a federal government 16 agency; right? 17 A. I haven't really gone into detail what 18 they are. But sure it sounds like a government 19 agency. 20 Q. You know they promulgate regulations 21 that are binding on hospitals that accept Medicaid 22 or Medicare money; correct? 23 A. Again, I haven't looked to their role in 24 that kind of detail.</p>

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<p style="text-align: right;">34</p> <p>1 Q. Let's see -- I'm looking at Dr. DiMaio's 2 Excited Delirium Syndrome: Cause of Death and 3 Prevention. And I want to read you a brief 4 section of this about excited delirium. It says 5 acute excited delirium is the section. The quote 6 is on initial presentation one cannot determine if 7 the excited delirium is due to intrinsic mental 8 disease or the drugs. In the emergency room one 9 has the theoretical advantage that one has access 10 to medications. Since such individuals are 11 virtually always struggling medication has to be 12 given intramuscularly. You agree with that? 13 A. I agree with parts of it, not all of it. 14 Q. Well, what part do you agree with? 15 A. That -- fortunately I would love to have 16 it in front of me to be able to give you an exact. 17 But we have the advantage of having medications in 18 the emergency department, sure I agree with that. 19 It's often difficult to tell the difference 20 clinically when you're looking at somebody whether 21 it's psychiatrically induced or drug induced. 22 Sometimes they can be very similar, I agree with 23 that. 24 Q. Right. But we don't have any issue</p>	<p style="text-align: right;">35</p> <p>1 about that here, do we, because Mrs. Goode 2 reported the LSD in time? 3 A. Correct. 4 Q. So that's not an issue? 5 A. You just asked me what I agreed with or 6 disagree -- you agree with in this thing. I just 7 gave you the parts that I agreed with that I can 8 recall. 9 Q. I understand. Now do you agree or 10 disagree with the statement since such individuals 11 are virtually always struggling medication has to 12 be given intramuscularly; do you agree or 13 disagree? 14 A. I would disagree. 15 Q. Well, the reason Dr. DiMaio, whether you 16 agree with it or not, says intramuscularly the 17 alternative is intravenously; correct? 18 A. That is one other alternative, sure. 19 Q. And IV is much more difficult to place 20 than sticking somebody in the arm or the butt with 21 a needle; right? 22 A. It technically would be considered more 23 challenging than an intramuscular injection, sure. 24 Q. Right. And Troy Goode had an ID placed</p>
<p style="text-align: right;">36</p> <p>1 by the paramedic; correct? 2 A. Correct. 3 Q. Which would indicate he was not so out 4 of control that she could not place an IV; 5 correct? 6 A. At the time that she was placing the IV 7 that would seem to be reasonable. 8 Q. Now you have asserted that LSD can cause 9 excited delirium; right? 10 A. I opine that it can, sure. 11 Q. Okay. And it is also true that LSD was 12 in its heyday in the '60s and '70s; correct? 13 A. It was used more frequently then, sure. 14 Q. More frequently. It was used -- do you 15 know who Timothy Leary was? 16 A. I'm sorry? 17 Q. Do you know who Timothy Leary was at 18 Harvard University? 19 A. The name is familiar. But I couldn't 20 give you any background on it. 21 Q. Well, what's your age? 22 A. I am 51. 23 Q. You remember the Grateful Dead? 24 A. Yes.</p>	<p style="text-align: right;">37</p> <p>1 Q. You know all the LSD concerts or all the 2 concerts where LSD was so prevalent? 3 A. Absolutely. 4 Q. Okay. And during the heyday of LSD 5 there were zero reporting deaths due to LSD; you 6 agree? 7 A. I wouldn't have researched that to the 8 point where I could agree or disagree. 9 Q. Okay. So you can't say -- you can't 10 point to one death in the heyday of LSD that was 11 attributed to LSD toxicity; right? 12 A. You're talking about toxicity or 13 behaviors associated with the drug? 14 Q. No. I'm not talking about behaviors. 15 I'm not talking about people going crazy and 16 jumping off buildings. I'm talking about toxicity 17 of the drug. 18 A. I think we talked earlier I don't 19 believe that the LSD is considered a drug that 20 typically is in and of itself a toxic drug that 21 kills based on it's chemistry. 22 Q. And you also agree that in the heyday of 23 LSD use there were zero reported cases of excited 24 delirium attributable to LSD complications;</p>

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<p>1 correct?</p> <p>2 A. In that day the term excited delirium</p> <p>3 hadn't actually been used. So it wouldn't have</p> <p>4 been put out there. That came out more in the</p> <p>5 times of the cocaine, heroin, they were seeing</p> <p>6 more deaths associated with it.</p> <p>7 Q. Actually the excited delirium or</p> <p>8 agitated excited delirium deaths had been reported</p> <p>9 back into the 19th Century in psychiatric</p> <p>10 patients; correct?</p> <p>11 A. Right. But you used the one term I</p> <p>12 think excited delirium, and that term wasn't</p> <p>13 really being used until the '80s. So you wouldn't</p> <p>14 expect to go and see LSD deaths secondary to</p> <p>15 excited delirium in the '60s or '70s. It wouldn't</p> <p>16 have been treated then.</p> <p>17 Q. Fair enough. In the '60s and '70s, did</p> <p>18 you see one death attributable to agitated</p> <p>19 delirium caused by LSD, one death?</p> <p>20 A. I didn't review the literature from the</p> <p>21 '60s and '70s. I know that since -- Ronald</p> <p>22 O'Halloran I believe reports of a death secondary</p> <p>23 to LSD and excited delirium in his case theories.</p> <p>24 Q. Ronald O'Halloran is a forensic</p>	<p>38</p> <p>1 pathologist?</p> <p>2 A. That is correct.</p> <p>3 Q. And Dr. O'Halloran has publicly stated</p> <p>4 that if hogtying in a prone position has nothing</p> <p>5 to do with the death of people under the influence</p> <p>6 of drugs, why does it always occur when those</p> <p>7 people are in police custody; correct?</p> <p>8 A. Why does it meaning the death or the --</p> <p>9 Q. Dr. O'Halloran has publicly stated that</p> <p>10 all deaths in hogtie restraints in excited</p> <p>11 delirium from drugs occur in police custody?</p> <p>12 A. He may have claimed that. I would</p> <p>13 disagree with it.</p> <p>14 Q. Okay. Now, Doctor, you do agree that</p> <p>15 when cocaine came on the scene in the 1980s and</p> <p>16 thereafter is when we saw the excited delirium</p> <p>17 deaths attributable to ingestion of that</p> <p>18 particular drug; right?</p> <p>19 A. That's the time period. Yes.</p> <p>20 Q. And cocaine and amphetamines are</p> <p>21 stimulants; right?</p> <p>22 A. They are stimulants. Yes.</p> <p>23 Q. Is it correct that in Dr. Gall's,</p> <p>24 G-A-L-L, forensic medicine that the descriptions</p>
<p>40</p> <p>1 of excited delirium like presentations in the late</p> <p>2 1800s and early 1900s were noted in the medical</p> <p>3 literature?</p> <p>4 A. Bell's mania and other names of it</p> <p>5 describe the subjects or patients presenting with</p> <p>6 symptoms consistent with excited delirium in that</p> <p>7 time period. Yes.</p> <p>8 Q. And going on quoting: At this time the</p> <p>9 reports of death from this syndrome started fading</p> <p>10 coinciding with the introduction of</p> <p>11 anti-psychotics for the treatment of agitated</p> <p>12 patients in psychiatric facilities. Right?</p> <p>13 A. The reports did start to go down because</p> <p>14 people were being treated with medications. Sure.</p> <p>15 Q. And they were down at the time that LSD</p> <p>16 came on the scene?</p> <p>17 A. I guess in that time period, yes the</p> <p>18 psychiatric patients were being treated with</p> <p>19 Thorazine and other anti-psychotics. And that was</p> <p>20 the same time period that LSD was out there.</p> <p>21 Sure.</p> <p>22 Q. You've stated that in your -- to your</p> <p>23 understanding Mr. Goode was hogtied; correct?</p> <p>24 A. Yes. He was in a prone maximal</p>	<p>41</p> <p>1 restraint position, also known as hogtie.</p> <p>2 Q. How long did he stay in that position?</p> <p>3 A. He was in it from the time the police</p> <p>4 officers put him in until the time he had his</p> <p>5 cardiac arrest. And that was somewhere about an</p> <p>6 hour and a half in that range.</p> <p>7 Q. Is it correct that people who are in a</p> <p>8 delusional state of excited delirium do not</p> <p>9 appreciate their surroundings?</p> <p>10 A. They are often altered by their</p> <p>11 surroundings. They see things. They hear things.</p> <p>12 What they interpret from their surroundings is</p> <p>13 often unknown because of what's going on in their</p> <p>14 head.</p> <p>15 Q. Is it correct that these people are not</p> <p>16 aware of their condition of delusional state?</p> <p>17 A. They typically don't recognize that</p> <p>18 they're delusional if that's what you're asking.</p> <p>19 They are just experiencing it. But they don't</p> <p>20 have an awareness of that delusion.</p> <p>21 Q. Certainly they don't know what they are</p> <p>22 doing; right?</p> <p>23 A. That is usually felt to be the case,</p> <p>24 yeah. They're unaware of what they're doing,</p>

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<p style="text-align: right;">42</p> <p>1 their activities. Sure.</p> <p>2 Q. They are unaware of being bound also;</p> <p>3 correct?</p> <p>4 A. They may realize they can't move. They</p> <p>5 may not know why or -- again, what's going on in</p> <p>6 their head with the drugs that are sort of</p> <p>7 swimming around and causing confusion and delusion</p> <p>8 is hard to say in every case it's the same way.</p> <p>9 Q. Well, you would agree that it would be</p> <p>10 unlikely that somebody in an extreme delusional</p> <p>11 state would know that he had been chained; right?</p> <p>12 A. It's possible that they sense something</p> <p>13 going on that somebody is holding them or</p> <p>14 dragging, holding them or -- it's hard to say</p> <p>15 what's happening. But they may recognize that</p> <p>16 they can't move. They may not recognize they</p> <p>17 can't move. Again, I think it's they're -- what's</p> <p>18 going on in their head is very difficult. But</p> <p>19 they may or may not be aware specifically.</p> <p>20 Q. Well, the state which you describe as</p> <p>21 excited delirium would be so extreme that a person</p> <p>22 would be highly unlikely to realize that he was in</p> <p>23 handcuffs, for instance?</p> <p>24 A. He may not recognize it was handcuffs.</p>	<p style="text-align: right;">43</p> <p>1 He may recognize that the devil is holding him or</p> <p>2 other things. Again, that's sort of the part of</p> <p>3 delusional stuff. He hey not know exactly what's</p> <p>4 going on, but he has probably some awareness. He</p> <p>5 recognizes -- they recognize people coming at them</p> <p>6 because they get paranoid and freak out. So there</p> <p>7 is a level of awareness. But how detailed that is</p> <p>8 or how accurate that is is really difficult for</p> <p>9 anybody to understand on all cases. It's usually</p> <p>10 more case individual.</p> <p>11 Q. You wouldn't expect a person in extreme</p> <p>12 excited delirium to yell out get me out of these</p> <p>13 chains, would you?</p> <p>14 A. They could. Sure.</p> <p>15 Q. How would they know they were in chains?</p> <p>16 A. They could be aware of it. They could</p> <p>17 have seen it. They could be heard jingling. They</p> <p>18 could be sensing the sounds, the feel. Again,</p> <p>19 it's a delusion. It's not -- it can wax and wane</p> <p>20 to some degree. But the reality is the level of</p> <p>21 awareness that is happening vary from people to</p> <p>22 people. I have seen all kinds of variations on</p> <p>23 how they seem to -- how they seem to interpret</p> <p>24 their environment and surroundings.</p>
<p style="text-align: right;">44</p> <p>1 Q. So what you're telling the jury is that</p> <p>2 there is no checklist as such for determining a</p> <p>3 person that is in excited delirium?</p> <p>4 A. I don't think I said that. I said that</p> <p>5 you can't completely define what they are</p> <p>6 interpreting their environment to be. There have</p> <p>7 been some people who say shoot me shoot me making</p> <p>8 an awareness that there might be a gun with the</p> <p>9 officer there. So there's different levels of</p> <p>10 awareness. But it doesn't mean that they are not</p> <p>11 delirious and interpreting their environment and</p> <p>12 what's going on correctly.</p> <p>13 Q. Very well. Let me ask you -- let's put</p> <p>14 that aside. When a person presents with these</p> <p>15 markers or these characteristics as you said of</p> <p>16 excited delirium and medical care arrives, that</p> <p>17 person in a state of excited delirium syndrome</p> <p>18 should receive pulse oximetry; correct?</p> <p>19 A. When feasible, sure. It's reasonable.</p> <p>20 Q. And when is not feasible?</p> <p>21 A. When they're moving so much that they</p> <p>22 can't either get a good tracing or it keeps</p> <p>23 falling off. You don't put something on somebody</p> <p>24 that is either grabbing the wires or can't keep it</p>	<p style="text-align: right;">45</p> <p>1 on their fingers. A lot of times in an acute</p> <p>2 agitated state people try to put it on but in</p> <p>3 general it ends up getting pulled off just by</p> <p>4 virtue of the movement.</p> <p>5 Q. For the jury's benefit there are</p> <p>6 different types of pulse oximeters; is that</p> <p>7 correct?</p> <p>8 A. There's different types of attachments</p> <p>9 if that's what you're getting at.</p> <p>10 Q. Right. One can go around the head;</p> <p>11 correct?</p> <p>12 A. For pediatrics. We don't typically use</p> <p>13 that in adults.</p> <p>14 Q. Well, Baptist Hospital does. Would you</p> <p>15 argue with that?</p> <p>16 A. I'm not aware of it. So I couldn't say</p> <p>17 one way or the another. But if his head was down</p> <p>18 on the ground it probably would not be as</p> <p>19 functional because of the movement and things like</p> <p>20 that. But I can't say that they did or didn't try</p> <p>21 it.</p> <p>22 Q. Well, if you place a pulse oximetry</p> <p>23 around the head it's not going to come -- be</p> <p>24 shaken off by somebody in hogtie; right?</p>

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<p style="text-align: right;">46</p> <p>1 A. It certainly could be. Sure.</p> <p>2 Q. Doctor, you understand that your</p> <p>3 opinions is suppose to be to a reasonable degree</p> <p>4 of medical certainty; right?</p> <p>5 A. Absolutely.</p> <p>6 Q. So all of this could be, and may be, and</p> <p>7 these hypotheticals you understand are not</p> <p>8 acceptable testimony; correct?</p> <p>9 A. If you're asking me questions I'm giving</p> <p>10 you the answers to those questions.</p> <p>11 Q. Has your testimony ever been excluded</p> <p>12 from a case? Have you ever been excluded, your</p> <p>13 testimony in whole or in part from any litigation?</p> <p>14 A. Not to my knowledge. No.</p> <p>15 Q. Did you testify in the case of Rich</p> <p>16 versus the City of Savannah Tennessee?</p> <p>17 A. I believe I did. Yes.</p> <p>18 Q. And the United States magistrate judge</p> <p>19 in that case held that you did not have the</p> <p>20 expertise to offer some of the opinions you tried</p> <p>21 to offer?</p> <p>22 A. I was not made aware of that.</p> <p>23 Q. In that case you were hired by the</p> <p>24 police after a man died in a confrontation with</p>	<p style="text-align: right;">47</p> <p>1 the police?</p> <p>2 A. That case is a long time ago. So I</p> <p>3 don't remember details of it. That certainly</p> <p>4 could be the case.</p> <p>5 Q. You attempted to testify that the cause</p> <p>6 of death was not related to asphyxia in Rich</p> <p>7 versus City of Savannah; right?</p> <p>8 A. Again, it's been a long time since I've</p> <p>9 reviewed that case. But it certainly would be</p> <p>10 possible.</p> <p>11 Q. Okay.</p> <p>12 MR. EDWARDS: Bobbie, let's mark as the</p> <p>13 next exhibit -- Bobbie, if you will, hold the</p> <p>14 second exhibit for the order of Judge Pham in the</p> <p>15 case of City of Savannah.</p> <p>16 THE REPORTER: I've done it.</p> <p>17 Mr. Edwards.</p> <p>18 MR. EDWARDS: Okay.</p> <p>19 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>20 WAS MARKED AS EXHIBIT NO. 2 TO THE TESTIMONY OF</p> <p>21 THE WITNESS AND ATTACHED HERETO.)</p> <p>22 BY MR. EDWARDS:</p> <p>23 Q. Doctor, take a look at that order and</p> <p>24 tell us that you were aware of the fact that Judge</p>
<p style="text-align: right;">48</p> <p>1 Pham excluded much of your testimony in the case</p> <p>2 of Rich versus City of Savannah?</p> <p>3 MR. GASS: Can I have the date the</p> <p>4 decision that's being referenced.</p> <p>5 MR. PHILLIPS: I think it's September</p> <p>6 30, 2005.</p> <p>7 MR. EDWARDS: That is correct.</p> <p>8 THE WITNESS: All right. Thank you.</p> <p>9 BY MR. EDWARDS:</p> <p>10 Q. Have you seen this order before?</p> <p>11 A. I have not. No.</p> <p>12 Q. Okay. So you were unaware that a</p> <p>13 federal judge here in Memphis had excluded some of</p> <p>14 your opinions?</p> <p>15 A. I was unaware of a federal judge like</p> <p>16 this. When I go to court they tell me the areas</p> <p>17 they want me to talk about. So it could have been</p> <p>18 that that's what happened here. But I was not</p> <p>19 aware of this order.</p> <p>20 Q. Fair enough. Now I was asking you about</p> <p>21 the things that should be done medically when a</p> <p>22 patient presents in a altered mental status like</p> <p>23 Mr. Goode. We talked about pulse oximetry is</p> <p>24 another thing which the paramedic should assess is</p>	<p style="text-align: right;">49</p> <p>1 for head trauma?</p> <p>2 A. You'll do an assessment of the patient</p> <p>3 the best you can. That's part of an evaluation.</p> <p>4 Sure.</p> <p>5 Q. Right. Head trauma would be included in</p> <p>6 assessing the patient?</p> <p>7 A. If feasible, sure you'll evaluate what</p> <p>8 you can with what you have in front of you. But</p> <p>9 that's part of an assessment, sure.</p> <p>10 Q. Well, why would somebody being hogtied</p> <p>11 not be able to have the condition of his head</p> <p>12 assessed?</p> <p>13 A. Sometimes you can't see the entire</p> <p>14 portion of the head. Sometimes you can depending</p> <p>15 on their positioning. With the agitation</p> <p>16 component you're not trying to completely disrupt</p> <p>17 and move around and create a lot of stimuli.</p> <p>18 You're trying to observe and evaluate, but you're</p> <p>19 not going to completely necessarily take off every</p> <p>20 piece of clothing to get a good assessment.</p> <p>21 You'll look -- based on the history on what you</p> <p>22 can see visually and look at somebody.</p> <p>23 Q. Did Mr. Goode have a hat on?</p> <p>24 A. I don't know. I don't believe he did.</p>

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<p>50</p> <p>1 Q. Another thing that should be done</p> <p>2 according to you is a glucose check; right?</p> <p>3 A. At some point a glucose should be</p> <p>4 checked. Yes.</p> <p>5 Q. Okay. And what is it that glucose</p> <p>6 levels would tell you as a physician?</p> <p>7 A. If they're very low that could be an</p> <p>8 etiology for the agitation, or extremely high it</p> <p>9 could be another medical condition, but probably</p> <p>10 not the cause of the agitation, but could be.</p> <p>11 Q. Was a glucose check done on Mr. Goode?</p> <p>12 A. It was. Yes.</p> <p>13 Q. Postmortem?</p> <p>14 A. I don't think so. I thought it was done</p> <p>15 prior to his death.</p> <p>16 Q. You have the medical records there and</p> <p>17 the EMT records; correct?</p> <p>18 A. Yes.</p> <p>19 Q. Show us where a glucose check was done</p> <p>20 prior to death by either the paramedics or the</p> <p>21 hospital personnel in the emergency department?</p> <p>22 A. There's a bedside glucose noted 2139 of</p> <p>23 95.</p> <p>24 Q. That's 17 minutes after the code was</p>	<p>51</p> <p>1 called; right?</p> <p>2 A. That would be --</p> <p>3 Q. He was dead?</p> <p>4 A. Well --</p> <p>5 Q. He was dead at that point?</p> <p>6 A. You asked me -- he wasn't pronounced</p> <p>7 dead until later than that. I'm sorry, I</p> <p>8 misunderstood your question. If you're asking was</p> <p>9 there a glucose done prior to his cardiac arrest,</p> <p>10 I don't believe it was done prior to his cardiac</p> <p>11 arrest.</p> <p>12 Q. Either by the EMS or the hospital</p> <p>13 personnel; correct?</p> <p>14 A. Not that I am aware of. A chemistry</p> <p>15 test is ordered prior to his cardiac arrest. But</p> <p>16 a bedside glucose was not done until the time we</p> <p>17 just talked about.</p> <p>18 Q. Tell the jury what's involved in doing a</p> <p>19 glucose check?</p> <p>20 A. Typically it's poking the finger with</p> <p>21 some sharp object, a prong or what not getting</p> <p>22 some blood sample and putting into a machine.</p> <p>23 Q. Right there at bedside?</p> <p>24 A. Can be done right at the bedside. Yes.</p>
<p>52</p> <p>1 Q. I mean, it's a very simple procedure,</p> <p>2 isn't it?</p> <p>3 A. Basically, yes it's fairly simple.</p> <p>4 Q. It is an essential part of the</p> <p>5 examination, the medical examination of a person</p> <p>6 deemed to be in excited delirium; correct?</p> <p>7 A. It is part of the evaluation in somebody</p> <p>8 presenting in excited delirium, particularly if</p> <p>9 there's not an inciting cause. But it's not -- I</p> <p>10 wouldn't call it essential.</p> <p>11 Q. Have you listed that -- you, Dr. Vilke</p> <p>12 listed glucose check as part of the exam of a</p> <p>13 person exhibiting the symptoms of Troy Goode?</p> <p>14 A. I have said that you should check a</p> <p>15 bedside glucose. Yes.</p> <p>16 Q. ECG is another thing that should be</p> <p>17 done; right?</p> <p>18 A. ECG as a 12-lead EKG or cardiac</p> <p>19 monitoring?</p> <p>20 Q. Either one. Was an ECG done in this</p> <p>21 case?</p> <p>22 A. There was a three lead done in the</p> <p>23 field. Yes.</p> <p>24 Q. And Lead 2 is the one that tells you</p>	<p>53</p> <p>1 whether somebody is in supraventricular</p> <p>2 tachycardia; correct?</p> <p>3 A. It's not necessarily a specific lead.</p> <p>4 You look at certain leads that give you the best</p> <p>5 reading.</p> <p>6 Q. Lead 2 is the one mentioned in the</p> <p>7 literature for determining SVT, supraventricular</p> <p>8 tachycardia?</p> <p>9 A. It can be used to look for SVT. But you</p> <p>10 cannot always tell whether somebody is an SVT</p> <p>11 based on a single lead tracing. Sometimes you</p> <p>12 need a 12 lead.</p> <p>13 Q. Yeah. Well, if you need a 12 lead then</p> <p>14 you do a 12 lead; right?</p> <p>15 A. That would be correct.</p> <p>16 Q. Was a 12 lead done?</p> <p>17 A. It was not done in this case. No.</p> <p>18 Q. It should have been done if there was</p> <p>19 any question about the diagnosis of SVT made by</p> <p>20 Paramedic Graham; correct?</p> <p>21 A. There is no doubt about the diagnosis</p> <p>22 it's not SVT. But in this case even if you wanted</p> <p>23 to get a 12 lead, it would have been impossible</p> <p>24 based on his behavior.</p>

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<p>54</p> <p>1 Q. Were you there, Doctor?</p> <p>2 A. I was not there.</p> <p>3 Q. Nurse Graham was able to get in -- I'm</p> <p>4 sorry, Paramedic Graham was able to get in an IV</p> <p>5 but she couldn't do an adequate ECG; is that what</p> <p>6 you're saying?</p> <p>7 A. Being specific she got an ECG a single</p> <p>8 lead tracing. It would not be feasible to do a</p> <p>9 12-lead EKG the way that Mr. Goode was described</p> <p>10 as behaving.</p> <p>11 Q. So it was okay for the paramedics and</p> <p>12 the hospital to disregard the finding which is</p> <p>13 recorded of SVT, that's good medicine? We're just</p> <p>14 going to disregard it because we don't think it's</p> <p>15 accurate; is that what you're saying?</p> <p>16 A. The paramedic recorded SVT. The rhythm</p> <p>17 strip does not show SVT. So there was no SVT to</p> <p>18 disregard even though it was documented in the</p> <p>19 paramedic record.</p> <p>20 Q. Is it good medicine to disregard a</p> <p>21 diagnosis without verifying that the diagnosis is</p> <p>22 incorrect is my question?</p> <p>23 A. Correct, paramedics do not make</p> <p>24 diagnosis. They do assessments. So there was no</p>	<p>55</p> <p>1 official diagnosis of SVT being made. They</p> <p>2 interpreted rhythm as being potential SVT. But</p> <p>3 there was no diagnosis of SVT in this case.</p> <p>4 Q. Did she record SVT?</p> <p>5 A. That is what she wrote in her record.</p> <p>6 Q. The paramedic wrote not once but twice</p> <p>7 SVT; right?</p> <p>8 A. As the monitor, not as a diagnosis.</p> <p>9 Q. Okay. And then so it was okay for the</p> <p>10 hospital, the emergency department to disregard</p> <p>11 that?</p> <p>12 A. I don't believe the tachycardia was</p> <p>13 disregarded by the hospital. They recognized --</p> <p>14 Q. It wasn't?</p> <p>15 A. They recognized that he was tachycardic</p> <p>16 and they started therapy for that, which was the</p> <p>17 sedation to slow his heart rate down.</p> <p>18 Q. How quickly was sedation commenced at</p> <p>19 the hospital?</p> <p>20 A. Shortly after the physician was able to</p> <p>21 evaluate the patient, it was ordered and</p> <p>22 commenced.</p> <p>23 Q. How long was that after he arrived at</p> <p>24 the hospital?</p>
<p>56</p> <p>1 A. He arrived at 2028. The order was</p> <p>2 placed approximately 2106.</p> <p>3 Q. So 36 minutes later?</p> <p>4 A. That looks about correct. Yes.</p> <p>5 Q. And it's also correct you -- you're an</p> <p>6 emergency physician; correct?</p> <p>7 A. I am. Yes.</p> <p>8 Q. You have worked in emergency</p> <p>9 departments; right?</p> <p>10 A. Yes.</p> <p>11 Q. Triage nurses can sedate people in Troy</p> <p>12 Goode's position; correct?</p> <p>13 A. Can sedate them in his condition?</p> <p>14 Q. Yeah.</p> <p>15 A. Not at our hospital, not without an</p> <p>16 order.</p> <p>17 Q. Sure. But if they a triage nurse</p> <p>18 determines that a patient is in excited delirium,</p> <p>19 they can simply ask the doctor for permission to</p> <p>20 administer something like Versed, for instance?</p> <p>21 A. A nurse can make a request. But a</p> <p>22 doctor is typically not going to do anything until</p> <p>23 they get some evaluation of the patient. Usually</p> <p>24 you want to see what's going on, get some history,</p>	<p>57</p> <p>1 get an assessment, vital signs the best you can</p> <p>2 before you start throwing meds at somebody. So a</p> <p>3 triage nurse can request it, doesn't mean they're</p> <p>4 going to get it.</p> <p>5 Q. How do you get the history?</p> <p>6 A. From the collateral history --</p> <p>7 Q. Of a patient that's delirious?</p> <p>8 A. I'm sorry, you interrupted me. I was</p> <p>9 saying the collateral history is helpful from</p> <p>10 either the EMTs or law enforcement that are</p> <p>11 accompanying them or the patient obviously if they</p> <p>12 can. In this case no.</p> <p>13 Q. As a matter of fact EMTs or paramedics</p> <p>14 can administer chemical restraints such as Versed</p> <p>15 in an ambulance if they deem it necessary; right?</p> <p>16 A. If the protocols allow and they meet</p> <p>17 criteria, there are certainly places that allow</p> <p>18 for sedation to be used by paramedics.</p> <p>19 Q. Mississippi does; correct?</p> <p>20 A. I don't know the protocols for</p> <p>21 Mississippi.</p> <p>22 Q. Assume that the Mississippi protocols</p> <p>23 allow the paramedic to administer a chemical</p> <p>24 restraint like Versed, obviously Ms. Graham didn't</p>

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<p style="text-align: right;">58</p> <p>1 deem it necessary to sedate Mr. Goode; correct?</p> <p>2 A. Just because protocols allow for</p> <p>3 something, you have to follow the protocol. I</p> <p>4 don't know the protocol, so I can't say whether or</p> <p>5 not it would have been appropriate or</p> <p>6 inappropriate to do it. I wasn't asked to review</p> <p>7 the paramedic's care in this case.</p> <p>8 Q. Well, you supervise paramedics; right?</p> <p>9 A. I have. Yes.</p> <p>10 Q. And you're qualified to speak about</p> <p>11 paramedics; right?</p> <p>12 A. I have been qualified, sure.</p> <p>13 Q. And you know that paramedics if the</p> <p>14 circumstances require can administer chemical</p> <p>15 restraints in an ambulance; correct?</p> <p>16 A. The word require is a strong word.</p> <p>17 Again, if protocols allow for it and they meet</p> <p>18 certain criteria and they don't meet certain</p> <p>19 exclusion criteria and their training and all that</p> <p>20 goes with it, then yes. Like I said, there are</p> <p>21 certain places that paramedics can give</p> <p>22 medications for agitated patients. I don't know</p> <p>23 the protocols here. I wasn't asked to evaluate</p> <p>24 their treatment of Mr. Goode.</p>	<p style="text-align: right;">59</p> <p>1 Q. And an agitated patient who is agitated</p> <p>2 due to LSD is a proper subject for a chemical</p> <p>3 restraint if he is truly out of control; correct?</p> <p>4 A. A person who is extremely agitated on</p> <p>5 any illicit drug can be a candidate for sedation</p> <p>6 in the appropriate setting with the appropriate</p> <p>7 background and history and depending on who is</p> <p>8 giving it which protocols and certain requirements</p> <p>9 are required before giving the medication.</p> <p>10 Q. So you don't know what the Mississippi</p> <p>11 protocol says one way or another?</p> <p>12 A. That's correct.</p> <p>13 Q. Okay. Now was Troy Goode an emergency?</p> <p>14 A. I'm sorry, was he an emergency?</p> <p>15 Q. Yes. Was he considered an emergency</p> <p>16 patient?</p> <p>17 A. We can consider this state a medical</p> <p>18 emergency for evaluation, sure. Compared to a cut</p> <p>19 or an ankle strain it's considered a medical</p> <p>20 emergency, sure.</p> <p>21 Q. And for emergency patients it is</p> <p>22 protocol to get them to the hospital as quickly as</p> <p>23 possible; right?</p> <p>24 A. As quickly and as safely as possible.</p>
<p style="text-align: right;">60</p> <p>1 That's one of the goals, sure.</p> <p>2 Q. What you do is if -- for EMS what they</p> <p>3 do is they turn on the ambulance lights so that</p> <p>4 they can be an emergency vehicle; correct?</p> <p>5 A. They can do it. Because of the risks</p> <p>6 associated with going fast lights and sirens</p> <p>7 there's lots of tiers in which -- even though the</p> <p>8 patient may be deemed a quote unquote emergency,</p> <p>9 you would still not go lights and sirens.</p> <p>10 Somebody with severe abdominal pain and a</p> <p>11 borderline heart rate and blood pressure would be</p> <p>12 an emergency, but you wouldn't go lights and</p> <p>13 sirens to get them to the hospital. So the</p> <p>14 protocol for lights and sirens vary from area to</p> <p>15 area.</p> <p>16 Q. Okay. So why don't we cut out some of</p> <p>17 this. We're not talking about people with</p> <p>18 abdominal problems. We're talking -- we're here</p> <p>19 about excited delirium; okay?</p> <p>20 A. Okay.</p> <p>21 Q. Is an excited delirium patient such as</p> <p>22 Mr. Goode considered a medical emergency; yes or</p> <p>23 no?</p> <p>24 A. The answer is we consider it a medical</p>	<p style="text-align: right;">61</p> <p>1 emergency, sure.</p> <p>2 Q. And a medical emergency is to be</p> <p>3 transferred emergently to the hospital; correct?</p> <p>4 A. Emergently or urgently. Again, if</p> <p>5 you're defining emergently by lights and sirens, I</p> <p>6 would not agree with that. I think they should go</p> <p>7 as quickly and safely as possible without the</p> <p>8 necessary need for lights and sirens in these</p> <p>9 cases.</p> <p>10 Q. You would certainly not sit for a number</p> <p>11 of minutes in the parking lot with the patient in</p> <p>12 the back taking no action, would you?</p> <p>13 A. I think that I -- I think that as far as</p> <p>14 no action you're doing nothing versus assessing</p> <p>15 and doing other things, you're asking me questions</p> <p>16 about the case I really didn't review.</p> <p>17 Q. Well, Doctor, look, you're coming in to</p> <p>18 testify about cause of death; right?</p> <p>19 A. Yes.</p> <p>20 Q. And don't you think it's important that</p> <p>21 you have all of the facts leading up to the death</p> <p>22 so you can render a valid opinion?</p> <p>23 A. The facts that are applicable to</p> <p>24 determine the cause of death, sure. What's being</p>

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<p style="text-align: right;">62</p> <p>1 done in the back of an ambulance during a period 2 of time is not applicable to determining cause of 3 death. Whether they were poking him with an IV, 4 doing an assessment, trying to get a pulse ox, 5 trying to put a lead on, or what you said doing 6 nothing, that doesn't apply to my determination of 7 cause of death. I have the times down that things 8 were going on, but not the necessary specific 9 second to second or minute to minute play by play 10 in the back of the ambulance. 11 Q. Does weight applied to Mr. Goode's back 12 when he was hogtied and prone have any impact on 13 your opinion? 14 A. At the time in the hospital or when are 15 you referring to? 16 Q. At any point in time. 17 A. In the case of his -- in looking at the 18 -- assessing the whole case, the answer would be 19 if weight was applied during the restraint process 20 by police, the fact that he was alive the next 21 hour plus, hour and a half plus, that would not 22 have any impact on my opinion as far as did the 23 weight have any causation to the cardiac arrest. 24 The straps are being used in the back of the</p>	<p style="text-align: right;">63</p> <p>1 ambulance if they were there and he got to the 2 hospital and they were removed and he was still 3 alive and kicking and struggling and showing signs 4 of life and good vital signs -- or not good vital 5 signs, but positive vital signs, that would not 6 impact my opinion. I note it, but it wouldn't 7 impact my opinion. 8 Q. Have you not seen cases where there was 9 a delayed asphyxiation death after application of 10 weight? 11 A. A delayed asphyxiation death after the 12 application of weight? 13 Q. Was there not a reported -- excuse me, 14 was there not a reported case of death two days 15 after application of weight due to asphyxiation? 16 A. I would be happy to review that. If 17 you're referring to somebody who had a cardiac 18 arrest at the time and was asphyxiated and died in 19 the hospital two days later, I guess that's a 20 feasible thing. But as far as somebody who had 21 weight on them and then they had their cardiac 22 arrest event two days later, I would certainly not 23 think that the weight had an impact on that. 24 Q. How much weight was put on Mr. Goode at</p>
<p style="text-align: right;">64</p> <p>1 any one time? 2 A. In the hospital there really wasn't much 3 weight at all on him at all. He was left on the 4 gurney. In the back of the ambulance he had some 5 straps on him. The weight that was used to try to 6 get him in custody by police was varying and moved 7 around. But the reality is the fact that they -- 8 after he was restrained he was assessed by 9 paramedics and assessed at the hospital and had a 10 blood pressure and a heart rate and was alive and 11 yelling and streaming. No matter what that weight 12 was, it wouldn't have impacted his outcome. It 13 wouldn't be part of his cardiac arrest. 14 Q. How many police put their weight on 15 Mr. Goode at the scene? 16 A. I seem to recall about intermittently 17 three police officers were back and forth. I 18 couldn't give you an exact time or amount. 19 Q. Do you believe that in a drug induced 20 excited delirium state where there is death, the 21 death is preceded by cycle of alternating struggle 22 and collapse? 23 A. I'm sorry, could you repeat that again, 24 please?</p>	<p style="text-align: right;">65</p> <p>1 Q. Yes. Is death in these circumstances 2 preceded by alternating cycle of alternating 3 struggle and collapse? 4 A. I would not say that that's necessarily 5 uniform, no. I think it's thought of struggle, 6 struggle, struggle. And then they have a cardiac 7 arrest is typically what you see, not necessarily 8 an alternating pattern. 9 Q. Let me give you a quote. "Death is 10 preceded by a cycle of alternating struggle and 11 collapse." Agree or disagree? 12 A. I can't interpret that sentence. If 13 you're talking about collapse as far as physical 14 exhaustion versus cardiac collapse or 15 cardiovascular collapse, I'm not sure what the 16 context is there. 17 Q. I'm just quoting Dr. DiMaio. 18 A. You're giving me one sentence. So, 19 again, I'm not sure what he means by collapse. So 20 I can't interpret that sentence. 21 Q. That's the whole sentence. That's all I 22 can give you. Was Mr. Goode ever bradycardic? 23 A. Not that I recall being -- during the 24 time before he had his cardiac arrest, he was not.</p>

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<p>1 Q. How do you know was he monitored?</p> <p>2 A. He was -- you mean as far as on a</p> <p>3 cardiac monitor, not consistently, no.</p> <p>4 Q. Was he monitored at all?</p> <p>5 A. Well, yeah. We have his rhythm strips.</p> <p>6 We know he was on a monitor for at least a small</p> <p>7 window of period to get that rhythm strip, but he</p> <p>8 was not --</p> <p>9 Q. Is that in the hospital record or the</p> <p>10 EMT record?</p> <p>11 A. The EMT record.</p> <p>12 Q. No, Doctor. At the hospital where he</p> <p>13 was there for an hour or so, was he ever monitored</p> <p>14 for cardiac rhythm?</p> <p>15 A. Sorry to upset you, I was just asking</p> <p>16 answering your question was he ever monitored, so</p> <p>17 we're at the hospital now. And he had pulse</p> <p>18 checked but he was not on a cardiac monitor prior</p> <p>19 to his cardiac arrest. He was monitored obviously</p> <p>20 after the cardiac arrest.</p> <p>21 Q. But that doesn't do much good, does it?</p> <p>22 A. Just answering your question.</p> <p>23 Q. So you can't say whether he was ever</p> <p>24 bradycardic or not; right?</p>	<p>66</p> <p>1 A. I can't say -- he certainly was not</p> <p>2 documented as bradycardic. His behavior would</p> <p>3 very consistent with bradycardic. But I can't say</p> <p>4 for the exact time he was in the hospital prior to</p> <p>5 his cardiac arrest that he was not bradycardic.</p> <p>6 Q. Can hypoxia cause cardiac arrest?</p> <p>7 A. Hypoxia can cause cardiac arrest. Yes.</p> <p>8 Q. When did Mr. Goode's -- was he</p> <p>9 dysrhythmic?</p> <p>10 A. He was tachycardic, which is some define</p> <p>11 as a dysrhythmia. And he obviously went into PEA</p> <p>12 which was a dysrhythmic event.</p> <p>13 Q. When did he become dysrhythmic?</p> <p>14 A. Well, again --</p> <p>15 Q. Can you tell us?</p> <p>16 A. If we're defining tachycardia as a</p> <p>17 dysrhythmia he was dysrhythmic the entire time.</p> <p>18 It's an irregular rhythm. It's not a normal sinus</p> <p>19 rhythm. It's a sinus tachycardia.</p> <p>20 Q. What you do medically to address</p> <p>21 dysrhythmia is what?</p> <p>22 A. You treat what you feel to be the cause</p> <p>23 of that dysrhythmia.</p> <p>24 Q. And I'm asking you what that is?</p>
<p>68</p> <p>1 A. Well, in this case it was a sinus</p> <p>2 tachycardia --</p> <p>3 Q. The treatment what was the treatment?</p> <p>4 A. Sure.</p> <p>5 Q. That should apply?</p> <p>6 A. In this case it was a sinus tachycardia</p> <p>7 most interpreted to be due to drug use and</p> <p>8 agitation. So you treat that by starting sedation</p> <p>9 medication to try to calm the person down, lower</p> <p>10 the heart rate based on that.</p> <p>11 Q. Actually you've testified that when you</p> <p>12 have people come in to your emergency department</p> <p>13 under the influence of LSD you often just put them</p> <p>14 over in the corner until they calm down; right?</p> <p>15 A. Depends on what their presentation style</p> <p>16 is. As you alluded to there's all kinds of</p> <p>17 presentations to LSD intoxication. If they're</p> <p>18 just mellow and tripping, then yeah you can watch</p> <p>19 them without a monitor in a corner somewhere. If</p> <p>20 they're extremely agitated, then you're going to</p> <p>21 try to use sedating medications to calm them.</p> <p>22 Q. As quickly as possible for the sedation</p> <p>23 medication?</p> <p>24 A. Possible and reasonable, sure.</p>	<p>69</p> <p>1 THE WITNESS: Would this be a good place</p> <p>2 to take a quick break?</p> <p>3 MR. EDWARDS: Sure.</p> <p>4 THE VIDEOGRAPHER: Time off the record</p> <p>5 is 9:22 a.m.</p> <p>6 (WHEREUPON, A BREAK WAS TAKEN AND THE</p> <p>7 PROCEEDINGS CONTINUED AS FOLLOWS:)</p> <p>8 THE VIDEOGRAPHER: Time back on the</p> <p>9 record is 9:30 a.m. This begins Media No. 2.</p> <p>10 Counsel, you may proceed.</p> <p>11 BY MR. EDWARDS:</p> <p>12 Q. Doctor, shifting to another subject, we</p> <p>13 talked about chemical sedations, chemical</p> <p>14 restraints. Haloperidol is a chemical restraint;</p> <p>15 correct?</p> <p>16 A. It's a medication used to sedate people.</p> <p>17 It can be considered a chemical restraint.</p> <p>18 Q. And was Haloperidol used on Mr. Goode?</p> <p>19 A. It was. Yes.</p> <p>20 Q. And it was inserted through an IV; is</p> <p>21 that correct?</p> <p>22 A. That's how it was administered. Yes.</p> <p>23 Q. You are aware that the FDA issued a</p> <p>24 black box warning against IV Haloperidol use?</p>

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<p style="text-align: right;">70</p> <p>1 A. There was a warning out for Haldol use.</p> <p>2 Q. And it's because there were deaths</p> <p>3 experienced after IV administration of Haldol or</p> <p>4 Haloperidol; correct?</p> <p>5 A. There were some reported deaths. Yes.</p> <p>6 Q. So the way Dr. Oliver ordered the</p> <p>7 administration of Haldol was against the warning</p> <p>8 from the FDA; right?</p> <p>9 A. Well, the warning is to be aware that</p> <p>10 this can happen. It's still the commonly used</p> <p>11 medication in the emergency departments across the</p> <p>12 U.S.</p> <p>13 Q. And if you're going to do that then you</p> <p>14 need to monitor the patient after you inject it;</p> <p>15 right?</p> <p>16 A. After you put the medication in there</p> <p>17 and as soon as you start monitoring you would</p> <p>18 watch the patient. Yes.</p> <p>19 Q. And why do you -- tell the jury why it</p> <p>20 is after you administer Haldol or Haloperidol that</p> <p>21 you must watch the patient?</p> <p>22 A. The black box warning basically says</p> <p>23 there is a few cases out of literally millions of</p> <p>24 administrations of Haldol that caused torsade de</p>	<p style="text-align: right;">71</p> <p>1 pointes, it's specific dysrhythmia that can kill</p> <p>2 somebody. And so you're going to watch to make</p> <p>3 sure if they go into it you're ready to treat it.</p> <p>4 Q. It's more than that, isn't it? If you</p> <p>5 administer Haldol it can change -- it can affect</p> <p>6 breathing; correct?</p> <p>7 A. It can affect, I'm sorry, what?</p> <p>8 Q. Breathing?</p> <p>9 A. Haloperidol? It's usually not</p> <p>10 considered something that would impede</p> <p>11 ventilations. It's a sedating medication, but</p> <p>12 it's usually not considered significantly</p> <p>13 ventilatory involved.</p> <p>14 Q. Can it change respiration?</p> <p>15 A. If it sedates somebody who is breathing</p> <p>16 quickly because they're agitated, then sure your</p> <p>17 respiratory rate might decrease. But it wouldn't</p> <p>18 change your ventilations.</p> <p>19 Q. Well, one of the things that people who</p> <p>20 are trained to do observation of patients that</p> <p>21 have received chemical restraints is look for</p> <p>22 changes in respirations; right?</p> <p>23 A. You're looking for -- you're following</p> <p>24 their breathing patterns, sure. That's fair.</p>
<p style="text-align: right;">72</p> <p>1 Q. All right. And you're also looking for</p> <p>2 changes in heart rate?</p> <p>3 A. At some point when you can monitor them</p> <p>4 you would reassess them for the sedating</p> <p>5 qualities. It should lower the heart rate.</p> <p>6 That's part of the purpose of using the medicine,</p> <p>7 sure.</p> <p>8 Q. By the way, was Mr. Goode's heart rate</p> <p>9 measured either by the EMS or the medical</p> <p>10 personnel at the hospital?</p> <p>11 A. It was. Yes.</p> <p>12 Q. And -- I asked the wrong question. Was</p> <p>13 his blood pressure taken?</p> <p>14 A. It was taken. Yes.</p> <p>15 Q. And what import, if any, that there was</p> <p>16 a 30 point drop in the diastolic within a few</p> <p>17 minutes?</p> <p>18 A. Physiologically and clinically it</p> <p>19 wouldn't have changed anything. The measurements</p> <p>20 in these types of patients sort of bounce around.</p> <p>21 And you measure, you know, five blood pressures</p> <p>22 you're going to get five different numbers, and</p> <p>23 they could be variable 20, 30 points depending on</p> <p>24 what's going on there.</p>	<p style="text-align: right;">73</p> <p>1 Q. Well, once again the only way to know</p> <p>2 that is by continuing to monitor; correct?</p> <p>3 A. If you wanted to recheck the blood</p> <p>4 pressure multiple times, sure. That's how you</p> <p>5 would do that.</p> <p>6 Q. And that was not done with Mr. Goode</p> <p>7 either, was it?</p> <p>8 A. He had several blood pressures checked</p> <p>9 during his time.</p> <p>10 Q. He had two blood pressures in the</p> <p>11 ambulance, but then his blood pressure was not</p> <p>12 monitored at the hospital; correct?</p> <p>13 A. I believe it was checked at the</p> <p>14 hospital.</p> <p>15 Q. You want to show us -- it was measured</p> <p>16 at 164 at one point; right?</p> <p>17 A. His heart rate I think was 164. His</p> <p>18 blood pressure was not that obviously.</p> <p>19 Q. His blood pressure was normal?</p> <p>20 A. That is what I recall.</p> <p>21 Q. All right. Is it accurate that --</p> <p>22 MR. EDWARDS: Well, first of all, let's</p> <p>23 mark the FDA black box.</p> <p>24 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p>

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<p style="text-align: right;">74</p> <p>1 WAS MARKED AS EXHIBIT NO. 3 TO THE TESTIMONY OF 2 THE WITNESS AND IS ATTACHED HERETO.) 3 BY MR. EDWARDS: 4 Q. Doctor, have studies Shown that more 5 than half of patients develop respiratory 6 depression in response to chemical restraints? 7 A. Have half the studies shown? 8 Q. No. Listen to the question. Have there 9 been studies, peer reviewed studies, publications 10 that have shown that more than half of patients 11 develop respiratory depression in response to 12 chemical restraints? 13 A. I know the patients will breathe less 14 than when they're agitated. So their ventilations 15 and respirations have been depressed from their 16 starting point. So that would make sense. It's 17 part of the sedation process. 18 Q. Are you familiar with the work of 19 Dr. Deitch, D-E-I-T-C-H, from two years ago on 20 unrecognized hypoxia and respiratory depression in 21 emergency department patients sedated for 22 psychomotor agitation? 23 A. I am not familiar off the top of my head 24 based on that title and author.</p>	<p style="text-align: right;">75</p> <p>1 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 2 WAS MARKED AS EXHIBIT NO. 4 TO THE TESTIMONY OF 3 THE WITNESS AND IS ATTACHED HERETO.) 4 BY MR. EDWARDS: 5 Q. Doctor, are you saying you're not 6 familiar with this? 7 A. May have reviewed it at some point. I'm 8 not familiar with the details of it right now. 9 Q. Okay. It was published in Western 10 Journal of Emergency Medicine; correct? 11 A. That is correct. 12 Q. Is that a reliable source for medical 13 information? 14 A. It is a peer reviewed journal. 15 Q. So is your answer yes it's deemed 16 reliable? 17 A. It's as reliable as the peer review is 18 reviewing it. That's what I'm getting at. 19 Q. Okay. Now Mr. Goode also received 20 Ativan; is that correct? 21 A. He did. Yes. 22 Q. And is it true that before chemical 23 restraints are applied that any underlying 24 disorder such as hypoxemia or hypoglycemia should</p>
<p style="text-align: right;">76</p> <p>1 be treated? 2 A. I apologize, I lost you in the question. 3 Can you please repeat it? 4 Q. Yes, I will be glad to. Is it accurate 5 to say that before sedating a patient any 6 underlying problem, medical problem should be 7 treated first as a potential pitfall as 8 administering anti-psychotics to a patient who 9 really has an underlying disorder such as 10 hypoxemia or hypoglycemia? 11 A. Ideally that would be the case if there 12 is a suspicion for it, if it's a diabetic or they 13 have a low O2 sats, joint hypoxia, you would want 14 to consider addressing those first. But sometimes 15 you do the evaluation after you give the 16 medication because of the agitation behavior. 17 Q. Are you aware that Mr. Goode had 18 moderate hypoxia -- 19 A. He had an O2 -- 20 Q. -- before receiving chemical restraints? 21 A. He had a documented O2 sat of 90 percent 22 which wouldn't be considered hypoxia that would 23 induce this type of behavior. So that would 24 basically rule out the concern for hypoxia in this</p>	<p style="text-align: right;">77</p> <p>1 patient. 2 Q. Doctor, is 90 percent low? 3 A. It is a low normal range. Yeah. 4 Q. Is it a condition which demands 5 supplemental oxygen administration? 6 A. It does not demand it. It can be 7 considered. 8 Q. It should be administered, correct, 9 supplemental oxygen? 10 A. Depending on the circumstances it should 11 be considered. But you have to take a look at the 12 entire picture. We're talking about specifically 13 this case or talking about an O2 sat of 90 percent 14 in general as a number. It's case specific. 15 Q. Well, the Mississippi SOPs for EMS say a 16 90 percent reading should receive supplemental 17 oxygen, would you take issue with that? 18 A. I think it's case by case. If you have 19 somebody who has Eisenmenger's syndrome their O2 20 sat may never get above 85. So you wouldn't need 21 to give them supplemental oxygen if that's where 22 they live. That's what I'm saying you have to 23 look at case by case. 24 Q. Well, case by case if you get a 90</p>

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<p>1 percent reading, you just ignore that?</p> <p>2 A. No.</p> <p>3 Q. What you do is you check it again;</p> <p>4 right?</p> <p>5 A. Or you look at the clinical scenario and</p> <p>6 see if that's appropriate for that patient or if</p> <p>7 it's even a correct reading in that patient.</p> <p>8 Q. What was Mr. Goode's O2 saturation after</p> <p>9 he was admitted to the hospital?</p> <p>10 A. The documented O2 sat was 90 percent.</p> <p>11 Q. And what was it 45 minutes later, 40</p> <p>12 minutes later when he coded?</p> <p>13 A. You can't pick up an O2 sat during a</p> <p>14 code basically. So you wouldn't be able to</p> <p>15 measure that.</p> <p>16 Q. Of course. What was it just before he</p> <p>17 coded?</p> <p>18 A. I don't have a number to share with you.</p> <p>19 Q. You have no idea, do you?</p> <p>20 A. I don't know what the number would be at</p> <p>21 that point. No.</p> <p>22 Q. Because the hospital didn't monitor his</p> <p>23 blood oxygen saturation; correct?</p> <p>24 A. Because of his behavior precluded the</p>	<p>78</p> <p>1 use of a O2 sat monitor to follow him.</p> <p>2 Q. That's what you've been told; correct?</p> <p>3 A. That's what I read throughout the</p> <p>4 record. Yes.</p> <p>5 Q. You have written repeatedly that for</p> <p>6 these types of patients O2 saturation monitoring</p> <p>7 is a requirement; correct?</p> <p>8 A. I don't believe I used the word</p> <p>9 requirement. And I said when feasible.</p> <p>10 Q. And are you saying -- have you ever had</p> <p>11 a patient that weighed 250 pounds or more who was</p> <p>12 in agitated delirium?</p> <p>13 A. Yes.</p> <p>14 Q. Did you manage that patient?</p> <p>15 A. Yes.</p> <p>16 Q. Actually in one of your testimonies or</p> <p>17 one of your reports you say you and two untrained</p> <p>18 unarmed security guards subdued a patient who was</p> <p>19 an agitated delirium just the three of you; right?</p> <p>20 A. I don't recall that. But I'd be happy</p> <p>21 to review that testimony.</p> <p>22 Q. You have done that though, haven't you?</p> <p>23 A. I've assisted with taking down patients</p> <p>24 who are agitated.</p>
<p>80</p> <p>1 Q. Yes. And the people that take them down</p> <p>2 typically are nurses; right?</p> <p>3 A. If the patient gets agitated in the</p> <p>4 emergency department they may be the ones.</p> <p>5 They're the first there to help out, sure.</p> <p>6 Q. You think that this -- giving you the</p> <p>7 benefit of the doubt this 170-pound bean pole was</p> <p>8 unmanageable?</p> <p>9 A. At what point are we talking about?</p> <p>10 Q. At any point. Have you seen pictures of</p> <p>11 Mr. Goode?</p> <p>12 A. I have seen some pictures of him. Yes.</p> <p>13 Q. He was an absolute rail, wasn't he?</p> <p>14 A. The BMI calculated about 24 which would</p> <p>15 make him the normal range.</p> <p>16 Q. He was a very skinny man, wasn't he?</p> <p>17 A. He was a normal man based on his body</p> <p>18 mass index for his height and weight.</p> <p>19 Q. Okay, fine. Giving you that, he</p> <p>20 certainly was not an NFL player, was he?</p> <p>21 A. Unless he was a puncher.</p> <p>22 Q. Doctor, when you give a chemical</p> <p>23 restraint that patient needs to be monitored;</p> <p>24 correct?</p>	<p>81</p> <p>1 A. The patient -- yeah. The patient should</p> <p>2 be monitored after a chemical restraint is</p> <p>3 utilized, sure.</p> <p>4 Q. Because -- and the monitoring needs to</p> <p>5 be done by a trained staff member --</p> <p>6 A. A trained --</p> <p>7 Q. -- of the hospital?</p> <p>8 A. A trained staff member will be doing the</p> <p>9 monitoring and reassessing of somebody, sure.</p> <p>10 That's what you do after you give medications.</p> <p>11 Q. And what you want in a hospital -- not</p> <p>12 what you want, what you must have is appropriate</p> <p>13 staff for monitoring to have the education,</p> <p>14 training and demonstrated knowledge based on the</p> <p>15 specific needs of the patient population in at</p> <p>16 least the following areas, one of which is the</p> <p>17 same application and use of all restraints or</p> <p>18 seclusion used in the hospital including in how to</p> <p>19 recognize and respond to signs and physical and</p> <p>20 psychological distress, for example, positional</p> <p>21 asphyxia; correct?</p> <p>22 A. That's a very long statement with a lot</p> <p>23 of parts to it. But basically if you have</p> <p>24 secluded or restrained or excited delirium</p>

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<p style="text-align: right;">82</p> <p>1 patients, you should be monitoring and reassessing</p> <p>2 them, paraphrasing the whole piece there. But,</p> <p>3 yeah overall the concept seems reasonable. I'd</p> <p>4 have to go through line by line to see if there</p> <p>5 are things that would be case by case, but the</p> <p>6 concept is reasonable.</p> <p>7 Q. The concept of positional asphyxia is</p> <p>8 something that a trained hospital staff member</p> <p>9 should be looking for is unequivocal; correct?</p> <p>10 A. Positional asphyxia, how are you</p> <p>11 defining that?</p> <p>12 Q. Doctor, come on, don't fence with me on</p> <p>13 this. You know what positional asphyxia is, don't</p> <p>14 you?</p> <p>15 A. I know different types.</p> <p>16 Q. You've written on it?</p> <p>17 A. Sorry, I apologize for upsetting you.</p> <p>18 I'm saying that there are a number of ways that</p> <p>19 people define positional asphyxia, particularly</p> <p>20 the hospital population, the elderly population</p> <p>21 with restraints and poseys and getting into</p> <p>22 positions within the gurney that can asphyxiate</p> <p>23 them. If you're referring to the class of law</p> <p>24 enforcement version where you put somebody on</p>	<p style="text-align: right;">83</p> <p>1 their stomach and hobble them and hogtie them in a</p> <p>2 prone maximal restrain position, that really is</p> <p>3 not a theory that's out there for hospitals to be</p> <p>4 overly concerned with.</p> <p>5 Q. Well, I'm using the definition that's</p> <p>6 used by the Center for Medicare and Medicaid</p> <p>7 Services, CMS.</p> <p>8 A. Okay.</p> <p>9 Q. Are you familiar with that?</p> <p>10 A. With their definition I'm not. No.</p> <p>11 Q. You work in an emergency department.</p> <p>12 Does your emergency department accept federal</p> <p>13 funds?</p> <p>14 A. We do. Yes.</p> <p>15 Q. And you don't know what is required of</p> <p>16 you in working in a hospital by the CMS that</p> <p>17 governs hospitals receiving federal funds; is that</p> <p>18 correct?</p> <p>19 A. Your question was do I know the</p> <p>20 definition of positional restraint I think by CMS</p> <p>21 and the answer --</p> <p>22 Q. That's not what I asked.</p> <p>23 A. Okay. Please ask your question again.</p> <p>24 Q. I asked you, you as a physician working</p>
<p style="text-align: right;">84</p> <p>1 in a CMS regulated hospital do not know what the</p> <p>2 requirements are of CMS for chemically restrained</p> <p>3 patient observation; is that correct?</p> <p>4 A. I know that we have certain requirements</p> <p>5 to follow and we have protocols that are set up to</p> <p>6 do that. But if you wanted me to go down a list</p> <p>7 of all of them off the top of my head, the answer</p> <p>8 would be no I couldn't give you that list off the</p> <p>9 top of my head.</p> <p>10 Q. You do know the monitoring the physical</p> <p>11 and psychological well being of a patient who is</p> <p>12 restrained, including, but not limited to</p> <p>13 respiratory and circulatory status, skin</p> <p>14 integrity, vital signs and any special</p> <p>15 requirements specified by hospital policy</p> <p>16 associated with the one hour face-to-face</p> <p>17 evaluation is required by CMS, you do know that,</p> <p>18 don't you?</p> <p>19 A. That's the practice that we tend to do</p> <p>20 in our hospital. So if it meets the requirements</p> <p>21 it would make sense. Right.</p> <p>22 Q. Baptist Memorial Hospital did not do</p> <p>23 that with Troy Goode; correct?</p> <p>24 A. They were monitoring him. They were --</p>	<p style="text-align: right;">85</p> <p>1 they did a set of vital signs. They were</p> <p>2 reevaluating him. And there's an hour-to-hour</p> <p>3 reassessment. So he was assessed at that time.</p> <p>4 Q. How did they monitor him?</p> <p>5 A. They could listen to him. They would</p> <p>6 come back and they had somebody else also just</p> <p>7 watching his physical well being. There is no</p> <p>8 requirement --</p> <p>9 Q. Who was watching his physical well</p> <p>10 being?</p> <p>11 A. At one point there was a police officer</p> <p>12 -- well, the whole time there's a police officer</p> <p>13 in the room.</p> <p>14 Q. What was his medical training?</p> <p>15 A. I don't know specifically what his</p> <p>16 medical training was.</p> <p>17 Q. What was his ability to detect</p> <p>18 respiratory distress?</p> <p>19 A. His ability to detect respiratory</p> <p>20 distress would be a change in status. And he</p> <p>21 actually did that.</p> <p>22 Q. Yes, when he stopped breathing. What</p> <p>23 was his ability to recognize agonal breathing?</p> <p>24 A. He reported that basically that the</p>

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<p>86</p> <p>1 change in breathing status was very irregular. He</p> <p>2 reported that out to nursing. That would be</p> <p>3 agonal breathing.</p> <p>4 Q. What medical training does that police</p> <p>5 officer have?</p> <p>6 A. Again, I earlier said I believe most of</p> <p>7 them have a basic medical or basic life support</p> <p>8 training as part of --</p> <p>9 Q. What medical training did Baggett have</p> <p>10 so that he was a trained qualified person to</p> <p>11 observe Troy Goode, Baggett?</p> <p>12 A. I said earlier most police officers have</p> <p>13 a basic --</p> <p>14 Q. I'm not asking you, Doctor. You're not</p> <p>15 answering the question. I'm asking you about</p> <p>16 Officer Baggett, not some police officer in San</p> <p>17 Diego.</p> <p>18 A. Okay.</p> <p>19 Q. What training did Baggett have?</p> <p>20 A. I don't know.</p> <p>21 Q. See that wasn't hard, was it? Is there</p> <p>22 a standardized definition of excited delirium that</p> <p>23 you can direct me to?</p> <p>24 A. Not a standardized definition that</p>	<p>87</p> <p>1 everybody has exact same language on, no.</p> <p>2 Q. All right. Are there clear reasons why</p> <p>3 patients that you deem to be an excited delirium</p> <p>4 die?</p> <p>5 A. Are there reasons why?</p> <p>6 Q. Are there clear reasons why some</p> <p>7 patients that you deem to be in excited delirium</p> <p>8 die?</p> <p>9 A. There really is no specific</p> <p>10 predictability of who -- if you have 10 in a room</p> <p>11 who might or might not die. There are certainly</p> <p>12 indicators postmortem and some premortem type</p> <p>13 things. But in general they're very difficult to</p> <p>14 tell who is going to go into cardiac arrest.</p> <p>15 Q. Did you produce a work entitled Excited</p> <p>16 Delirium Redefining an Old Diagnosis?</p> <p>17 A. I did write a paper I believe with that</p> <p>18 title. Yes.</p> <p>19 MR. EDWARDS: Give us just one second,</p> <p>20 we'll locate that and we'll mark that.</p> <p>21 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>22 WAS MARKED AS EXHIBIT NO. 5 TO THE TESTIMONY OF</p> <p>23 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>24 BY MR. EDWARDS:</p>
<p>88</p> <p>1 Q. Doctor, you authored this paper or this</p> <p>2 report?</p> <p>3 A. It looks like it. Yes.</p> <p>4 Q. And sent it to an attorney in Rhode</p> <p>5 Island?</p> <p>6 A. Or Connecticut maybe -- or is it Rhode</p> <p>7 Island? Yeah, I guess it was Rhode Island based</p> <p>8 on this. Sure.</p> <p>9 Q. Okay. Now in this whatever this report,</p> <p>10 if you will, you noted that early recognition of</p> <p>11 cardiac arrest and prompt treatment will increase</p> <p>12 survivability immensely; is that correct?</p> <p>13 A. What page are you on there, I'm sorry?</p> <p>14 Q. Page 4.</p> <p>15 A. I did write that yeah, for V-fib arrest.</p> <p>16 Correct.</p> <p>17 Q. Okay. So that being the case, doesn't</p> <p>18 it follows, does it not, that you need a medically</p> <p>19 trained person who is competent to detect a</p> <p>20 cardiac arrest and observe?</p> <p>21 A. Well, to determine a cardiac arrest does</p> <p>22 not obtain a medical degree of training. It's</p> <p>23 basically change in status.</p> <p>24 Q. And a change in status might be</p>	<p>89</p> <p>1 observed; correct?</p> <p>2 A. A change in status is basically going</p> <p>3 from responsive to unresponsive or to stop</p> <p>4 breathing, that would be the change in status</p> <p>5 you're looking for and that doesn't require</p> <p>6 specific medical training to observe that.</p> <p>7 Q. How do you know that Officer Baggett was</p> <p>8 even looking at Mr. Goode immediately prior to the</p> <p>9 change in status, how do you know that?</p> <p>10 A. His testimony was talking about the fact</p> <p>11 that he was making noises, yelling, talking,</p> <p>12 whatever it was, and then there was a change in</p> <p>13 status, and so he went over to look at him. So he</p> <p>14 was hearing which is a part of the assessment. If</p> <p>15 he's yelling and talking and making noises, he is</p> <p>16 basically breathing and moving air in. When there</p> <p>17 was a change the officer reported that he went to</p> <p>18 assess him or take a look at him.</p> <p>19 Q. Do you know that Officer Baggett was not</p> <p>20 on his cell phone with his girlfriend?</p> <p>21 A. That was not reported. But I can't say</p> <p>22 because, I was not in the room.</p> <p>23 Q. The best way to detect a change in</p> <p>24 cardiac status is by looking at rhythm strips;</p>

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<p>1 correct?</p> <p>2 A. A rhythm strip would if it was reading</p> <p>3 would show a change in status, that would be</p> <p>4 correct.</p> <p>5 Q. And that would take a medically trained</p> <p>6 person to notice it on a rhythm strip?</p> <p>7 A. To some degree depending on what the</p> <p>8 rhythm change was. If it went from the blipping</p> <p>9 QRS complex that we see it's a flat line, you</p> <p>10 know, that's common that people could recognize</p> <p>11 that without having to be medically trained when</p> <p>12 the alarms go off.</p> <p>13 Q. In your hospital do you have any</p> <p>14 non-medically trained people monitoring rhythm</p> <p>15 strips?</p> <p>16 A. Rhythm strips, no.</p> <p>17 MR. EDWARDS: Did you mark that, Bobbie?</p> <p>18 THE REPORTER: Yes, I did. It's No. 5.</p> <p>19 MR. EDWARDS: Okay. For number six we</p> <p>20 are missing that. Will you hold that?</p> <p>21 THE REPORTER: Yes, I will.</p> <p>22 BY MR. EDWARDS:</p> <p>23 Q. Doctor, is it also true that agitation</p> <p>24 and excited delirium is surprisingly common with</p>	<p>1 as many as 1.7 million episodes of agitation</p> <p>2 annually in excited delirium in the United States?</p> <p>3 A. That didn't make sense, I apologize.</p> <p>4 Q. Okay. Let me reask it because I'm</p> <p>5 advised that I left out in emergency departments</p> <p>6 is the frequency of excited delirium surprisingly</p> <p>7 common?</p> <p>8 A. It does happen in emergency departments.</p> <p>9 Surprisingly common is a -- I guess a relative</p> <p>10 term.</p> <p>11 Q. Well, yeah, but those are your words in</p> <p>12 the publication of psychiatric emergencies in</p> <p>13 pregnant women; correct?</p> <p>14 A. Excited delirium in pregnant women, that</p> <p>15 I'm not sure is -- I'd like to see that</p> <p>16 publication before I comment on that part.</p> <p>17 Q. Okay. Are there a number of things</p> <p>18 which can cause excited delirium?</p> <p>19 A. That cause excited delirium, was that</p> <p>20 your question?</p> <p>21 Q. Yes.</p> <p>22 A. There are a number of things depending</p> <p>23 on how much you want to break them down. The two</p> <p>24 major categories are untreated psychiatric</p>
<p>1 disorders and typically stimulant drugs are the</p> <p>2 two big categories.</p> <p>3 Q. Can hypoglycemia cause agitation?</p> <p>4 A. It can cause agitation. Yes.</p> <p>5 Q. Can heat stroke?</p> <p>6 A. Cause agitation, yes.</p> <p>7 Q. Can thyroid disorders?</p> <p>8 A. Cause agitation, yes.</p> <p>9 Q. Psychiatric issues you already</p> <p>10 mentioned; right?</p> <p>11 A. Correct.</p> <p>12 Q. And psychotropic drugs used to treat</p> <p>13 psychiatric issues in and of themselves can cause</p> <p>14 a condition which appears to be excited delirium;</p> <p>15 right?</p> <p>16 A. It can cause agitation and symptoms that</p> <p>17 would be similar to some of the symptoms or</p> <p>18 characteristics of excited delirium.</p> <p>19 Q. Right. And withdrawal from those drugs</p> <p>20 can also cause symptoms which appear to be</p> <p>21 attendant to excited delirium; right?</p> <p>22 A. Again, similar characteristics can come</p> <p>23 from drug withdrawal. Yes.</p> <p>24 Q. Emotional reactions from stressful</p>	<p>1 situations can cause agitate -- agitation</p> <p>2 appearing to be excited delirium?</p> <p>3 A. It can have agitation with some</p> <p>4 characteristics that could be similar to agitated</p> <p>5 delirium.</p> <p>6 Q. So it's fair to say there are a number</p> <p>7 of things which can reproduce a state of agitation</p> <p>8 which have characteristics to use your word of</p> <p>9 agitated delirium; correct?</p> <p>10 A. Some characteristics. Yes.</p> <p>11 Q. In the -- did you author a treatise</p> <p>12 entitled Guidelines For Investigating Officer</p> <p>13 Involved Shootings?</p> <p>14 A. A book you mean or --</p> <p>15 Q. Whatever. Is it a paper or a book, what</p> <p>16 is it?</p> <p>17 A. The title is familiar. I need to look</p> <p>18 at -- I've authored many things. It sounds</p> <p>19 familiar though.</p> <p>20 Q. Well, what's interesting -- here I'll</p> <p>21 show it to you. Can you see this?</p> <p>22 A. Yes.</p> <p>23 Q. It says Guidelines for Investigating</p> <p>24 Officer Involved Shootings, Arrest Related Deaths</p>

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<p>1 and Deaths in Custody.</p> <p>2 A. Yes.</p> <p>3 Q. Darrell L. Ross, Gary M. Vilke. That's</p> <p>4 you, isn't it?</p> <p>5 A. That is correct.</p> <p>6 Q. And this strangely has a publication</p> <p>7 date of 2018. Can you explain that?</p> <p>8 A. I do not know how publishers work. No,</p> <p>9 I do not. It just came out this past year.</p> <p>10 Q. Okay. But this is a recent publication</p> <p>11 by you; right?</p> <p>12 A. I'm one of the editors. Yes.</p> <p>13 Q. One of the editors. Are the contents of</p> <p>14 it reliable?</p> <p>15 A. As reliable as the authors and the</p> <p>16 editors, sure.</p> <p>17 Q. Well, would you have included anything</p> <p>18 in your compilation which you deem to be</p> <p>19 unreliable?</p> <p>20 A. That would not be the intent. No.</p> <p>21 Q. You have testified in a number of cases</p> <p>22 that there are predisposing physical conditions to</p> <p>23 death in a person exhibiting characteristics of</p> <p>24 excited delirium; is that correct?</p>	<p>94</p> <p>95</p> <p>1 A. There are -- yes. There are certain</p> <p>2 predisposing conditions that would predispose them</p> <p>3 for having a cardiac arrest. Yes.</p> <p>4 Q. And some of those predisposing</p> <p>5 conditions are what?</p> <p>6 A. Cardiac enlargement, you know,</p> <p>7 ventricular hypertrophy, coronary artery blockages</p> <p>8 or bridging veins, bridging arteries, kidney</p> <p>9 failure, elevated potassium, things like that.</p> <p>10 Q. Okay. Mr. Goode had which one of those?</p> <p>11 A. I didn't see those -- any of those in</p> <p>12 Mr. Goode.</p> <p>13 Q. Another thing that you wrote might be a</p> <p>14 predisposing condition to death in excited</p> <p>15 delirium was sickle cell syndrome; is that</p> <p>16 correct?</p> <p>17 A. That can be a predisposing factor. Yes.</p> <p>18 Q. And why is that?</p> <p>19 A. Because it's -- under physiologic stress</p> <p>20 can cause the red cells to sickle and decrease</p> <p>21 blood flow to various organs.</p> <p>22 Q. Did Mr. Goode have any pre-existing</p> <p>23 conditions which you would deem would have put him</p> <p>24 at risk for excited delirium death?</p>
<p>96</p> <p>1 A. I think usually I refer to as increased</p> <p>2 risk for cardiac arrest that can be exacerbated by</p> <p>3 the excited delirium. But in his case I didn't</p> <p>4 see any other predisposing factors.</p> <p>5 Q. Can respiratory diseases increase risk</p> <p>6 for death in excited delirium?</p> <p>7 A. Respiratory diseases have not been shown</p> <p>8 to cause or contribute to cardiac arrest unless</p> <p>9 there is an acute event going on with it, meaning</p> <p>10 if he was having an acute asthma attack that would</p> <p>11 be a different potential issue complicating</p> <p>12 feature, but no. Other than that, the history of</p> <p>13 asthma in and of itself would not be considered a</p> <p>14 complicating predisposing factor.</p> <p>15 Q. In the studies that you've done with</p> <p>16 Chan and Neuman on this subject you excluded</p> <p>17 participants that had a history of asthma;</p> <p>18 correct?</p> <p>19 A. In some of the studies, yes. In others,</p> <p>20 no.</p> <p>21 Q. In any of the studies that you knowingly</p> <p>22 include somebody with a history of asthma?</p> <p>23 A. Yes.</p> <p>24 Q. Which study was that?</p>	<p>97</p> <p>1 A. I'd have to look specifically. It was</p> <p>2 either the pepper spray restraint study or the</p> <p>3 study with 25 and 50 pounds of weight on the back.</p> <p>4 Q. Well, we don't have any involvement with</p> <p>5 pepper stray here, would you agree?</p> <p>6 A. I agree.</p> <p>7 Q. In this text this guidelines for</p> <p>8 investigating officer involved shootings, et</p> <p>9 cetera, you state "Whether this behavior and</p> <p>10 clinical presentation represents a true diagnosis</p> <p>11 or syndrome remains controversial in medical</p> <p>12 literature." Is that accurate?</p> <p>13 A. There are people who argue different</p> <p>14 directions, so that would make it controversial.</p> <p>15 So that would be make it accurate, sure.</p> <p>16 Q. All right. There is a lack of consensus</p> <p>17 in the medical community whether excited delirium</p> <p>18 even exist. You wrote that?</p> <p>19 A. Again, if there are dissenting people</p> <p>20 who don't agree you don't have consensus. So that</p> <p>21 would be accurate.</p> <p>22 Q. And you know that some medical examiners</p> <p>23 have asked why is it that the police are always</p> <p>24 present when somebody dies of excited delirium;</p>

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<p style="text-align: right;">98</p> <p>1 right?</p> <p>2 A. I have heard that asked by at least one</p> <p>3 medical examiner.</p> <p>4 Q. Well, the 2015 AAFS seminar brochure</p> <p>5 contains that statement in it. Are you aware of</p> <p>6 that?</p> <p>7 A. Not particularly.</p> <p>8 Q. What -- you note in your book which --</p> <p>9 THE WITNESS: Bobbie, let's reserve a</p> <p>10 number for the doctor's book which we will</p> <p>11 maintain at our presence. It can be obtained --</p> <p>12 it is available on Amazon as is everything else in</p> <p>13 the world for anybody who wants to get it.</p> <p>14 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>15 WAS MARKED AS EXHIBIT NO. 7 TO THE TESTIMONY OF</p> <p>16 THE WITNESS AND IS NOT ATTACHED HERETO.)</p> <p>17 BY MR. EDWARDS:</p> <p>18 Q. You wrote in your book, Doctor, or you</p> <p>19 included in your book medical literature includes</p> <p>20 suggestions that excited delirium "is a fabricated</p> <p>21 diagnosis that was created to cover up police</p> <p>22 brutality." Did you include that in your book?</p> <p>23 A. That is the opinions of some authors.</p> <p>24 And so for completeness I believe it was included</p>	<p style="text-align: right;">99</p> <p>1 in there. Yes.</p> <p>2 Q. You also note that many of the people</p> <p>3 who die from excited delirium or allegedly were</p> <p>4 restrained prior to being arrested and</p> <p>5 transported. Is that correct?</p> <p>6 A. They're restrained I guess after being</p> <p>7 arrested and transported. Yes.</p> <p>8 Q. And you also note -- you address the</p> <p>9 prone maximal restraint position which is the</p> <p>10 hogtie in your book; right?</p> <p>11 A. There is writings on that. Yes.</p> <p>12 Q. What physical evidence in this case is</p> <p>13 there that would in your mind allow you to rule</p> <p>14 out the cause of death as being excited delirium?</p> <p>15 A. To rule out the cause of death?</p> <p>16 Q. Yes, sir. What evidence, what</p> <p>17 exclusionary evidence is there that would allow</p> <p>18 you to rule out the cause of death as excited</p> <p>19 delirium?</p> <p>20 A. There wasn't any that I could find. So</p> <p>21 he didn't have anything on autopsy that was an</p> <p>22 obvious other cause of death. The history</p> <p>23 mechanism were consistent with it. So I couldn't</p> <p>24 rule out excited delirium because I think it is</p>
<p style="text-align: right;">100</p> <p>1 the cause of death.</p> <p>2 Q. Low oxygen saturation is not consistent</p> <p>3 with a prone restraint in hogtie, is it?</p> <p>4 A. A low oxygen saturation?</p> <p>5 Q. Yes, sir. From your studies?</p> <p>6 A. In the studies the position did not</p> <p>7 lower one's O2 saturation, that's correct.</p> <p>8 Q. I just asked you about ruling out.</p> <p>9 Hyperthermia -- hyper.</p> <p>10 MR. EDWARDS: It's hyper, Bobbie, not</p> <p>11 hypo.</p> <p>12 BY MR. EDWARDS:</p> <p>13 Q. Hyperthermia is invariably associated</p> <p>14 with excited delirium deaths; correct?</p> <p>15 A. It is common in excited delirium deaths.</p> <p>16 It's not universal.</p> <p>17 Q. Well, that's not what Dr. Stratton said</p> <p>18 from the LA studies, is it?</p> <p>19 A. From his pre-hospital studies or his</p> <p>20 case series?</p> <p>21 Q. The paper upon which you relied, the LA</p> <p>22 Studies where they had the study a group of 221</p> <p>23 people with the characteristics of excited</p> <p>24 delirium. Dr. Stratton wrote hyperthermia is</p>	<p style="text-align: right;">101</p> <p>1 invariably associated with excited delirium</p> <p>2 deaths; correct?</p> <p>3 A. I don't recall that specific line. So</p> <p>4 I'd have to review the paper. But like I said, I</p> <p>5 know that hyperthermia is common in patients who</p> <p>6 have death from excited delirium.</p> <p>7 Q. Mr. Goode was not hyperthermic?</p> <p>8 A. There was no --</p> <p>9 Q. Correct?</p> <p>10 A. There was no documentation for core body</p> <p>11 temperature. But the attempted oral temperature</p> <p>12 was not elevated.</p> <p>13 Q. Well, you know that Dr. Barnhart the</p> <p>14 forensic pathologist that did the autopsy</p> <p>15 specifically looked for hyperthermia; right?</p> <p>16 A. In the medical records so did I. Yes.</p> <p>17 Q. Well, she wrote in her report that he</p> <p>18 was not hyperthermic; right?</p> <p>19 A. There was no evidence of hyperthermia</p> <p>20 because there's no other documented core body</p> <p>21 temperature. But I don't remember exactly how she</p> <p>22 worded it.</p> <p>23 Q. And for that reason she did not put</p> <p>24 cause of death as excited delirium; correct?</p>

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<p style="text-align: right;">102</p> <p>1 A. She did not write it in her report. But</p> <p>2 she reported it in her deposition.</p> <p>3 Q. Right. When prompted by Mr. Phillips</p> <p>4 she said oh, yeah that's what I mean by</p> <p>5 complications of LSD is excited delirium, that's</p> <p>6 what we're talking about?</p> <p>7 MR. PHILLIPS: Object to the statements</p> <p>8 of counsel and the characterization of the</p> <p>9 testimony.</p> <p>10 BY MR. EDWARDS:</p> <p>11 Q. Is that what she wrote, Doctor?</p> <p>12 A. Sorry. She said that it was excited</p> <p>13 delirium that she felt was the cause of death that</p> <p>14 was the complicating factor of the LSD.</p> <p>15 Q. Then why didn't she just put excited</p> <p>16 delirium, that's what Dr. DiMaio said to do?</p> <p>17 A. Based on her deposition she would have</p> <p>18 preferred to see a core body temperature had been</p> <p>19 documented and it wasn't. So she chose to</p> <p>20 document the way she did, but describe it the way</p> <p>21 she did in deposition.</p> <p>22 Q. If a death in custody -- a death in</p> <p>23 restraint in custody occurs, should that be</p> <p>24 classified as homicide?</p>	<p style="text-align: right;">103</p> <p>1 A. That is an area that I don't opine in.</p> <p>2 That's more of a medical examiner pathology area.</p> <p>3 So I don't give opinions on that topic of manner</p> <p>4 of death.</p> <p>5 Q. You're opining on cause of death which</p> <p>6 is not your field of expertise; right?</p> <p>7 A. I work with cause of death on a regular</p> <p>8 basis in the emergency department. I don't</p> <p>9 determine manner of death which is what you're</p> <p>10 asking me.</p> <p>11 Q. You don't do autopsies; right?</p> <p>12 A. That is correct.</p> <p>13 Q. You've never had any training in</p> <p>14 forensic pathology?</p> <p>15 A. Emergency medicine is one giant forensic</p> <p>16 evaluation of patients who come in altered. So</p> <p>17 we're seeing patients in the process of dying,</p> <p>18 immediately after dying, and resuscitated from</p> <p>19 dying. So we have a lot of evaluation skills with</p> <p>20 regards to causes of death. I just don't do</p> <p>21 manner of death.</p> <p>22 Q. Do you agree that hyperthermia is a</p> <p>23 harbinger of a bad outcome in persons with excited</p> <p>24 delirium?</p>
<p style="text-align: right;">104</p> <p>1 A. Yes. Somebody with elevated body</p> <p>2 temperature is at increased risk to going into</p> <p>3 cardiac arrest if in a state of excited delirium.</p> <p>4 Q. Therefore, it would be standard of care</p> <p>5 for a hospital with a patient in perceived excited</p> <p>6 delirium to have their temperature monitored;</p> <p>7 right?</p> <p>8 A. Ideally at some point during the</p> <p>9 evaluation a core body temperature would be</p> <p>10 obtained when feasible. Yes.</p> <p>11 Q. Well, if hyperthermia is a harbinger of</p> <p>12 bad outcome in persons with excited delirium, you</p> <p>13 got to know what the temperature level is to know</p> <p>14 if they're in hyperthermia; correct?</p> <p>15 A. When you can obtain a core body</p> <p>16 temperature that would be optimal. But like many</p> <p>17 other things in the excited state it's very</p> <p>18 difficult to obtain safely in acute agitated</p> <p>19 phase.</p> <p>20 Q. Where in your book do you put all of</p> <p>21 these qualifications that you're throwing out now?</p> <p>22 If you can obtain them, you don't say that in</p> <p>23 here, do you?</p> <p>24 A. That's --</p>	<p style="text-align: right;">105</p> <p>1 Q. You say yes -- you say do this for a</p> <p>2 person in excited delirium. You list A, B, C and</p> <p>3 D. You don't say do this if you can A, B, C and</p> <p>4 D; correct?</p> <p>5 MR. PHILLIPS: I object to your being</p> <p>6 argumentative with the witness and being abusive</p> <p>7 to the witness and you're not even giving him a</p> <p>8 chance to answer the questions you're posing.</p> <p>9 MR. EDWARDS: Well, that's noted.</p> <p>10 Overruled.</p> <p>11 BY MR. EDWARDS:</p> <p>12 Q. Go ahead, Doctor.</p> <p>13 A. The textbook there is for the evaluation</p> <p>14 afterwards. It's more based on the postmortem</p> <p>15 evaluation, but there is some treatment categories</p> <p>16 in there. But almost every paper that I can think</p> <p>17 of is qualified by when feasible or when possible</p> <p>18 or when safe, not just to stick a rectal probe in</p> <p>19 a jumping, bouncing, moving around guy and create</p> <p>20 the risk for more injury. You wait until they're</p> <p>21 sedated then you get a better evaluation.</p> <p>22 Q. That's all that would have been required</p> <p>23 was a thermometer in the rectum?</p> <p>24 A. You make it sound very easy to do in a</p>

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<p style="text-align: right;">106</p> <p>1 agitated patient. But that is how you would get a</p> <p>2 core body temperature ultimately.</p> <p>3 Q. Doctor, one of the studies that you</p> <p>4 quoted in this book Guidelines for Investigating</p> <p>5 Officer Involved Shootings, et cetera, was one by</p> <p>6 Dr. Mash, M-A-S-H?</p> <p>7 A. Okay.</p> <p>8 Q. Right?</p> <p>9 A. She is probably one of the references in</p> <p>10 that book, sure.</p> <p>11 Q. And you quoted a two protein biomarker</p> <p>12 signature can serve as a reliable forensic tool</p> <p>13 for identifying the excited delirium syndrome at</p> <p>14 autopsy. Do you agree?</p> <p>15 A. That is a paraphrasing of her research,</p> <p>16 but basically there are markers that she has</p> <p>17 identified in certain portions of the brain that</p> <p>18 are consistently different in patients who have</p> <p>19 signs and symptoms consistent with excited</p> <p>20 delirium versus other causes of death.</p> <p>21 Q. And you believe based on those studies</p> <p>22 that you can rely -- determine whether a person</p> <p>23 has excited delirium on autopsy?</p> <p>24 A. Based on her reports and publications if</p>	<p style="text-align: right;">107</p> <p>1 the brain meets the certain criteria that she has</p> <p>2 studied over the years, it would be consistent</p> <p>3 with a diagnosis of excited delirium. And she's</p> <p>4 comfortable saying that that's what that is if all</p> <p>5 the clinical features match up.</p> <p>6 Q. Was there any such finding in Troy</p> <p>7 Goode?</p> <p>8 A. I am not aware that his brain was sent</p> <p>9 to a Deb Mash's lab in Miami.</p> <p>10 Q. Are you saying that Dr. Barnhart was not</p> <p>11 competent to make that determination?</p> <p>12 A. I didn't say that. I'm saying that this</p> <p>13 is a specialized test that as far as I know is</p> <p>14 only done at the brain center down in the</p> <p>15 university of Miami. So that every pathologist</p> <p>16 across the country doesn't do this study. And I'm</p> <p>17 not aware of any others that actually do. So</p> <p>18 Dr. Barnhart would fall in that category rather</p> <p>19 than what you described incompetence.</p> <p>20 Q. Well, okay. So you don't have any</p> <p>21 evidence of the two protein biomarker signature;</p> <p>22 right?</p> <p>23 A. Again, I wasn't aware that the brain was</p> <p>24 sent for that specific study to Deb Mash, so no.</p>
<p style="text-align: right;">108</p> <p>1 Q. Now well you understand about prophanine</p> <p>2 transporter of proteins and heat shock protein 70</p> <p>3 in the brain with person with excited delirium,</p> <p>4 you have any appreciation of that?</p> <p>5 A. Just the concepts that the dopamine</p> <p>6 transported are down regulated and increases</p> <p>7 amounts of dopamine in the system which sort of</p> <p>8 revs up the system and that is thought one of the</p> <p>9 potential mechanisms of why the excited delirium</p> <p>10 physiologic characteristics develop.</p> <p>11 Q. Okay. On autopsy in Mr. Goode there was</p> <p>12 no protein biomarker signature indicative of</p> <p>13 excited delirium found; correct?</p> <p>14 A. Again, these are things that tend to be</p> <p>15 done at the specialized lab in Miami. So not that</p> <p>16 I'm aware of, no.</p> <p>17 Q. Okay. Is the heat shock protein 70 a</p> <p>18 protein in the brain that accumulates in response</p> <p>19 to hyperthermia?</p> <p>20 A. I'm not sure if it's in response to or</p> <p>21 introduces hyperthermia. It seems to be</p> <p>22 associated with hyperthermia.</p> <p>23 Q. Okay. You agree that Troy -- there's no</p> <p>24 evidence that Troy was ever hyperthermic; correct?</p>	<p style="text-align: right;">109</p> <p>1 A. There was no documented elevated</p> <p>2 temperature in Troy Goode.</p> <p>3 Q. Do you have any undocumented evidence in</p> <p>4 your opinion that would indicate that he was</p> <p>5 hyperthermic?</p> <p>6 A. The only documentation of physiology</p> <p>7 that could be consistent with it was some</p> <p>8 diaphoresis noted by the paramedics. But that was</p> <p>9 really the only temperature that was taken was an</p> <p>10 oral temperature that was reported to be tucked</p> <p>11 into a cheek which is obviously not a reliable</p> <p>12 core body temperature. So I didn't see anything</p> <p>13 that showed hyperthermia.</p> <p>14 Q. Did you give an expert report in the</p> <p>15 case of Stetter, S-T-E-T-T-E-R versus Hanover</p> <p>16 Park?</p> <p>17 A. I was involved in that case. Yes.</p> <p>18 Q. Is that a case where you retracted your</p> <p>19 opinion that excited delirium was the cause of</p> <p>20 death?</p> <p>21 A. I don't recall that.</p> <p>22 Q. You were hired by the police in that</p> <p>23 case also; right?</p> <p>24 A. I would have to review that. I don't</p>

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<p style="text-align: right;">110</p> <p>1 remember specifically who hired me, whether it was 2 the city, the police. I don't remember who hired 3 me in that case.</p> <p>4 Q. Well, we're not talking about the police 5 I'm talking about a governmental entity. Those 6 are the only entities that you work for, right, 7 for the police and the government?</p> <p>8 A. Sometimes hospitals and individuals 9 depending on what the lawsuits are. But in 10 general it's the municipalities.</p> <p>11 Q. Yeah, you're right. I should qualify my 12 question. Civil rights cases you only testify for 13 the police departments; correct?</p> <p>14 A. I testify -- I think in the past number 15 of years they're the ones who approach me for my 16 opinions. And if needed I testify for them, yes.</p> <p>17 Q. Let's see if we agree on this. Once an 18 excited delirium patient is delivered to a 19 hospital by the EMS, that patient becomes the 20 responsibility of the emergency room physician and 21 the hospital personnel; correct?</p> <p>22 A. I mean, they certainly have a level of 23 responsibility, sure. There's a hand off at some 24 point.</p>	<p style="text-align: right;">111</p> <p>1 THE WITNESS: And whenever you have a 2 time for another five-minute break, I would 3 appreciate it whenever is a good time for you.</p> <p>4 MR. EDWARDS: Go right ahead. Let's 5 take it.</p> <p>6 THE VIDEOGRAPHER: Time off the record 7 is 10:25 a.m.</p> <p>8 (WHEREUPON, A BREAK WAS TAKEN AND THE 9 PROCEEDINGS CONTINUED AS FOLLOWS:)</p> <p>10 THE VIDEOGRAPHER: Time back on the 11 record is 10:33 a.m. Counsel, you may proceed.</p> <p>12 MR. EDWARDS: Thank you. Bobbie, would 13 you hand the doctor Exhibit 4.</p> <p>14 BY MR. EDWARDS:</p> <p>15 Q. Doctor, I'm sorry, did you say that you 16 were not familiar with this?</p> <p>17 A. I may have looked at it at some point, 18 but I don't recall the specifics of it.</p> <p>19 Q. Okay. This is dealing with the study by 20 Dr. Deitch about respiratory depression at 21 chemical restraint; is that correct sir?</p> <p>22 A. That is what they're looking for in the 23 study looks like. Yes.</p> <p>24 Q. And you said well respiratory depression</p>
<p style="text-align: right;">112</p> <p>1 just means that they could go from elevated 2 respiration to normal respiration; is that 3 correct?</p> <p>4 A. I said if you're defining that as 5 respiratory depression, then that would be a form 6 of depression. Yes.</p> <p>7 Q. Except Dr. Deitch found that nearly half 8 of the people after chemical restraint developed 9 hypoxia, low blood oxygen; correct?</p> <p>10 A. I haven't read this paper in detail to 11 give you that answer, but I can check for sure.</p> <p>12 Q. Nearly half. So assuming that that's 13 correct nearly half of the people receiving 14 chemical restraint go into hypoxia, that requires 15 close monitoring after chemical restraint, does it 16 not?</p> <p>17 A. If there was hypoxia involved, 18 monitoring would be part of the evaluation of that 19 hypoxia, sure.</p> <p>20 Q. Well, no, if chemical restraints result 21 in nearly half of the people receiving the 22 restraints developing hypoxia, just makes common 23 sense that somebody trained medically needs to 24 observe those people; correct?</p>	<p style="text-align: right;">113</p> <p>1 A. Again, it depends on the case, the type 2 of patient, the evaluation. But based on the 3 study, they define looks like hypoxia is O2 sat of 4 93 percent or less for greater than 15 seconds. 5 But as far as the patient population, the 6 medications, and what was being used, and what was 7 the indications for it, I haven't had a chance to 8 better evaluate this paper to see applicability in 9 this case.</p> <p>10 Q. Would you agree -- well, Dr. Deitch 11 defines hypoxia below 93 percent?</p> <p>12 A. Ninety-three percent or less. Yes.</p> <p>13 Q. And Mr. Goode the only reading we have 14 on him was 90 percent; correct?</p> <p>15 A. That's the only documented reading. 16 Yes.</p> <p>17 Q. And would you agree that hypoxia is 18 rarely recognized by doctors unless the patient is 19 being monitored by pulse oximetry?</p> <p>20 A. Hypoxia is typically defined by pulse 21 oximetry. So as far as if you're looking -- 22 doctors don't recognize hypoxia. They tend to 23 recognize signs or symptoms of ventilatory 24 impairment or respiratory problems, but not</p>

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<p style="text-align: right;">114</p> <p>1 defining hypoxia.</p> <p>2 Q. Well, the purpose of pulse oximetry is</p> <p>3 to see how much oxygen a patient is getting into</p> <p>4 the bloodstream; right?</p> <p>5 A. How much of their red cells are</p> <p>6 oxygenated by oxygen. Yes.</p> <p>7 Q. You can't tell that by looking at a</p> <p>8 person, can you?</p> <p>9 A. You can't give a -- create a number that</p> <p>10 way, no. You can't look and say that's a 96 or a</p> <p>11 92, no.</p> <p>12 Q. I want to go back to the chemical</p> <p>13 restraints administered to Mr. Goode. We said one</p> <p>14 of them was the Haldol and the other was Ativan;</p> <p>15 is that correct?</p> <p>16 A. Yes.</p> <p>17 Q. And Ativan is used for what purpose?</p> <p>18 A. It's a benzodiazepine anxiolytic and has</p> <p>19 sedation properties to help calm and relax people.</p> <p>20 Q. Do you agree that the most important</p> <p>21 risk associated with use of Ativan injection is</p> <p>22 respiratory depression?</p> <p>23 A. It's certainly one of the areas that we</p> <p>24 want to look into watch. It's very important to</p>	<p style="text-align: right;">115</p> <p>1 watch for the ventilatory effects of</p> <p>2 benzodiazepines.</p> <p>3 Q. Right. It says, and I'm referring to</p> <p>4 the -- I'm referring to the package insert. And</p> <p>5 it says accordingly, airway patency must be</p> <p>6 assured and respiration monitored closely; right?</p> <p>7 That's appropriate?</p> <p>8 A. You want to make sure they have an open</p> <p>9 airway and that they're breathing. That's</p> <p>10 reasonable, sure.</p> <p>11 Q. And that's done again by pulse oximetry</p> <p>12 among other things?</p> <p>13 A. That is one way of doing it.</p> <p>14 Q. And Mr. Goode was not monitored for his</p> <p>15 respiration; correct?</p> <p>16 A. He was not on a continuous pulse</p> <p>17 oximetry.</p> <p>18 Q. He was not monitored except during --</p> <p>19 the only reading that they got on his pulse</p> <p>20 oximetry or by pulse oximetry was in triage at the</p> <p>21 hospital; correct?</p> <p>22 A. That was the only pulse oximetry reading</p> <p>23 that I saw.</p> <p>24 MR. EDWARDS: Bobbie, this is on the</p>
<p style="text-align: right;">116</p> <p>1 exhibit list number 23 and if you would mark</p> <p>2 that -- on our exhibit list, if you would mark</p> <p>3 that as the next exhibit please.</p> <p>4 MR. GASS: Is this Exhibit 8?</p> <p>5 THE REPORTER: Yes. It is Exhibit 8.</p> <p>6 MR. GASS: Can we have the title of it,</p> <p>7 please.</p> <p>8 MR. EDWARDS: It's the package insert</p> <p>9 for Ativan.</p> <p>10 MR. GASS: Tim, I'll tell you with the</p> <p>11 echo that's created with you being on a different</p> <p>12 audio, it's almost impossible to understand what</p> <p>13 you just said.</p> <p>14 THE WITNESS: I'll say it. It says that</p> <p>15 Ativan (lorazepam) injection IV. It's reportedly</p> <p>16 the package inserts. Looks like it's typed out</p> <p>17 and it's approximately 20 pages.</p> <p>18 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>19 WAS MARKED AS EXHIBIT NO. 8 TO THE TESTIMONY OF</p> <p>20 THE WITNESS AND ATTACHED HERETO.)</p> <p>21 BY MR. EDWARDS:</p> <p>22 Q. Doctor, do you agree that when a person</p> <p>23 is restrained in a hogtie that that triggers what</p> <p>24 laypeople call the flight or fight syndrome?</p>	<p style="text-align: right;">117</p> <p>1 A. Restraint can cause a flight or fight</p> <p>2 syndrome. It doesn't always doesn't have to.</p> <p>3 Q. Are you familiar with a study done by</p> <p>4 Dr. Barnett entitled Perceptions of supported and</p> <p>5 unsupported prone-restraint positions?</p> <p>6 A. Sounds familiar but I couldn't go</p> <p>7 through the details of the study for you.</p> <p>8 Q. Well, I'll get you a copy.</p> <p>9 MR. EDWARDS: Bobbie, it's No. 11 on our</p> <p>10 list.</p> <p>11 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>12 WAS MARKED AS EXHIBIT NO. 9 TO THE TESTIMONY OF</p> <p>13 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>14 BY MR. EDWARDS:</p> <p>15 Q. Doctor, looking at this, does this</p> <p>16 refresh your memory that you've seen this paper</p> <p>17 before?</p> <p>18 A. It vaguely familiar. But I don't</p> <p>19 remember the details of how they did the study.</p> <p>20 Q. Okay. It was published in the Journal</p> <p>21 of Psychiatric and Mental Health Nursing. You see</p> <p>22 that?</p> <p>23 A. Yes.</p> <p>24 Q. Okay. Do you know anything about the</p>

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<p style="text-align: right;">118</p> <p>1 study or the results that were reached?</p> <p>2 A. I would probably have to answer that no</p> <p>3 at this point.</p> <p>4 Q. Okay. If you assume that two positions</p> <p>5 were studied. One involved prone position with</p> <p>6 arms straight out at the sides. The other</p> <p>7 involving a prone position with arms supporting</p> <p>8 the chest to avoid pressure on the chest wall</p> <p>9 okay. Are you with me?</p> <p>10 A. Yes.</p> <p>11 Q. Would you agree that both of those</p> <p>12 positions that I just described are less confining</p> <p>13 than being hogtied?</p> <p>14 A. I mean, it's a different type of</p> <p>15 confinement for the supported prone position. But</p> <p>16 they are -- certainly have more movement</p> <p>17 availability in parts view one and two.</p> <p>18 Q. Are you surprised that the results of</p> <p>19 testing those two positions showed that a</p> <p>20 supported position allowed for greater oxygenation</p> <p>21 where the chest was not pressed down upon the</p> <p>22 surface?</p> <p>23 A. I would be surprised that the</p> <p>24 unsupported prone position had any changes in</p>	<p style="text-align: right;">119</p> <p>1 oxygenation. So that's -- I would be surprised if</p> <p>2 there was a difference between the two to be</p> <p>3 honest.</p> <p>4 Q. Okay. Have you seen the Baptist -- have</p> <p>5 you seen any of the Baptist protocols?</p> <p>6 A. I have not. No.</p> <p>7 Q. Would you -- assume that there is a</p> <p>8 Baptist protocol that warrants against putting any</p> <p>9 pressure on a patient's back who is in the prone</p> <p>10 position because of dangers to the patient. Would</p> <p>11 you agree or disagree with that protocol or with</p> <p>12 that policy?</p> <p>13 A. Well, that seems very vague and</p> <p>14 generalized. I mean, if you're doing back surgery</p> <p>15 on somebody they're going to be prone and you're</p> <p>16 going to be putting pressure on them, so it seems</p> <p>17 like a odd specific language in a protocol.</p> <p>18 Q. Well, if Baptist has that protocol,</p> <p>19 would you take issue with the assumption that by</p> <p>20 placing any pressure on the patient's back</p> <p>21 endangered the patient?</p> <p>22 A. I would.</p> <p>23 MR. UPCHURCH: Object to the form. This</p> <p>24 is David Upchurch.</p>
<p style="text-align: right;">120</p> <p>1 A. I would have to look at the whole</p> <p>2 content. But I think patients are in the prone</p> <p>3 positions on a regular basis for various reasons,</p> <p>4 wound care, dressing changes, things like that.</p> <p>5 So there's going to be pressure. So I would be</p> <p>6 surprised if this protocol specifically said no</p> <p>7 pressure should be applied. That's really the</p> <p>8 extent I probably would comment on it right now.</p> <p>9 BY MR. EDWARDS:</p> <p>10 Q. Well, if it does you disagree with it;</p> <p>11 is that fair?</p> <p>12 A. I would not agree or disagree. I would</p> <p>13 just say it seems to be a little bit broader than</p> <p>14 what need to be in a typical policy.</p> <p>15 Q. Is LSD -- help me with this</p> <p>16 pronunciation, a sympathomimetic agent?</p> <p>17 A. It is a stimulant more in the</p> <p>18 hallucinogenic family. But it also has stimulant</p> <p>19 properties.</p> <p>20 Q. What's the basis for your statement that</p> <p>21 it has stimulant properties?</p> <p>22 A. That's just what's known in the medical</p> <p>23 literature, in toxicologic literature.</p> <p>24 Q. I want you to point me to the literature</p>	<p style="text-align: right;">121</p> <p>1 that says that LSD is a stimulant?</p> <p>2 A. I think it's sort of generalized known.</p> <p>3 I'd have to actually look to see where it's</p> <p>4 written down. I know it's there. I just -- it's</p> <p>5 sort of a more of a common knowledge than a</p> <p>6 area -- but I can certainly look for a reference</p> <p>7 if you'd like. But I don't have them off the top</p> <p>8 of my head.</p> <p>9 Q. Well, actually, I researched it the most</p> <p>10 is a Dr. Nichols at UNC and he says it's not. Do</p> <p>11 you have any basis to disagree with Dr. Nichols?</p> <p>12 A. That it doesn't have stimulants</p> <p>13 properties, I would definitely disagree with that.</p> <p>14 It does raise heart rate. It does increase</p> <p>15 breathing rate. Those are stimulant properties.</p> <p>16 Q. I asked you if LSD is a sympathomimetic,</p> <p>17 that's S-Y-M-P-A-T-H-O-M-I-M-E-T-C, agent?</p> <p>18 A. Sympathomimetic. It certainly has</p> <p>19 stimulant properties. That's what I'm sort of</p> <p>20 saying. Those are actually -- it's classified as</p> <p>21 a stimulant or a hallucinogenic with stimulant</p> <p>22 properties which would define it that is has</p> <p>23 having sympathomimetic components to it.</p> <p>24 Q. Like to the extent of cocaine?</p>

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<p>122</p> <p>1 A. Not to that extreme. No.</p> <p>2 Q. To the extent of methamphetamine?</p> <p>3 A. Not typically, no.</p> <p>4 Q. Those drugs are the ones most commonly</p> <p>5 associated with the syndrome you term excited</p> <p>6 delirium; right?</p> <p>7 A. That would be correct.</p> <p>8 Q. And as we said here today you can't</p> <p>9 point me to any authority that says LSD is a</p> <p>10 sympathomimetic agent; correct?</p> <p>11 A. Or have stimulant properties, again,</p> <p>12 it's sort of common knowledge in the emergency</p> <p>13 department that we see patients with the stimulant</p> <p>14 changes associated with LSD. But, again, having</p> <p>15 to refer to a direct quote, no I'd have to look</p> <p>16 that up for you.</p> <p>17 Q. Okay. That's all I ask. So your answer</p> <p>18 is no you can't tell me as we sit here today an</p> <p>19 authority that would support the proposition</p> <p>20 you're asserting that is that LSD is a stimulant?</p> <p>21 A. That has stimulant like qualities, yes.</p> <p>22 Q. Okay. Are you familiar with the work by</p> <p>23 Dr. Hick, Metabolic Acidosis in Restraint-</p> <p>24 associated Cardiac Arrest?</p>	<p>123</p> <p>1 A. I have reviewed that in the past, yes.</p> <p>2 Q. Do you disagree with Dr. Hick's</p> <p>3 conclusion -- well, what was his conclusion in</p> <p>4 that study?</p> <p>5 A. I've read hundreds if not thousands of</p> <p>6 studies over the last 15 years. I don't remember</p> <p>7 his exact conclusion, I apologize.</p> <p>8 Q. Do you agree with the statement in that</p> <p>9 study "continued combativeness despite restraints</p> <p>10 especially in the setting of sympathomimetic</p> <p>11 agents such as cocaine seems to be a marker for</p> <p>12 patients at higher risk for death regardless of</p> <p>13 pathophysiology." Do you agree with that?</p> <p>14 A. I mean, patients who continue to</p> <p>15 struggle and struggle, I think you said despite</p> <p>16 restraints, certainly will continue to create</p> <p>17 acidosis and would be considered to be a higher</p> <p>18 risk than somebody who didn't, yeah.</p> <p>19 Q. So then it follows that the appropriate</p> <p>20 medical response as you have said is to get the</p> <p>21 patient out of the flight or fight syndrome as</p> <p>22 soon as possible; correct?</p> <p>23 A. I don't think I ever said that. I think</p> <p>24 I said to start the sedation process to try to</p>
<p>124</p> <p>1 calm them.</p> <p>2 Q. As soon as possible?</p> <p>3 A. As soon as possible and safe. Yes.</p> <p>4 Q. In this case you are aware that there</p> <p>5 was no effort to sedate Mr. Goode until well after</p> <p>6 he had arrived at the hospital, are you?</p> <p>7 A. Effort if you're defining an order and</p> <p>8 administration that took time. But all the effort</p> <p>9 is to get him into a room, get him evaluated, try</p> <p>10 to get vital signs, that's all part of the effort</p> <p>11 to prepare to decide what sedation should be used,</p> <p>12 what medical therapy should be administered.</p> <p>13 Q. Are you -- at your hospital do you use</p> <p>14 the emergency severity index triage flow chart?</p> <p>15 A. The ESI scores. Yes.</p> <p>16 Q. What is that for our benefit?</p> <p>17 A. It's typically a way that nurses triage</p> <p>18 patients in certain categories based on certain</p> <p>19 criteria. Five being the least acute. One being</p> <p>20 the most acute.</p> <p>21 MR. EDWARDS: Bobbie, before we go on</p> <p>22 this article by Dr. Hick is our No. 17 and should</p> <p>23 be marked as the next exhibit.</p> <p>24 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p>	<p>125</p> <p>1 WAS MARKED AS EXHIBIT NO. 10 TO THE TESTIMONY OF</p> <p>2 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>3 MR. EDWARDS: Then pull out our number</p> <p>4 48.</p> <p>5 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>6 WAS MARKED AS EXHIBIT NO. 11 TO THE TESTIMONY OF</p> <p>7 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>8 BY MR. EDWARDS:</p> <p>9 Q. Doctor, is this the index you were</p> <p>10 referring to that you utilize?</p> <p>11 A. This is what our nurses utilize in our</p> <p>12 department as well. Yes.</p> <p>13 Q. It gives us five categories. Severity</p> <p>14 one being immediately the lifesaving intervention?</p> <p>15 A. Correct.</p> <p>16 Q. And it provides a step by step approach</p> <p>17 to clinical decision making?</p> <p>18 A. It does look like it has a step by step</p> <p>19 sort of protocol or algorithm here. Yes.</p> <p>20 Q. And it gives -- yeah, okay. It gives an</p> <p>21 algorithm of -- each step of the algorithm guides</p> <p>22 the user towards the appropriate questions to ask</p> <p>23 or the type of information to gather?</p> <p>24 A. Yes. This looks like it's sort of an</p>

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<p style="text-align: right;">126</p> <p>1 overview of the indexes is what the chapter is 2 defined as. But it gives some data to how to 3 interpret certain aspects. 4 Q. Now are you aware that Baptist has 5 adopted this ESI index? 6 A. Can't say I was necessarily aware of it, 7 but it wouldn't surprise me. 8 Q. You would expect it though; right? 9 A. They usually some sort of a triaging 10 score. It would not be unreasonable. 11 Q. Under the ESI protocol the first 12 question is whether a patient requires immediate 13 lifesaving intervention? 14 A. You're on Page 8 of this -- number eight 15 on the second page of this; is that right? 16 Q. Yes, sir. 17 A. Okay. It's the Figure 2-1a ESI Triage 18 Algorithm? 19 Q. Yes. 20 A. Okay. 21 Q. First question is whether the patient 22 requires immediate lifesaving intervention; right? 23 A. That's what the box says. Yes. 24 Q. All right. Then it says a patient needs</p>	<p style="text-align: right;">127</p> <p>1 immediate life-saving intervention if they require 2 airway, emergency medications, or other 3 hemodynamic interventions and/or any of following 4 clinical conditions: intubated, apneic, pulseless, 5 severe respiratory distress, SPO2 less than 90, 6 acute mental status changes or unresponsive; is 7 that correct? 8 A. That is what they list in the box on the 9 right. 10 Q. And so Mr. Goode was at 90 percent SPO2; 11 right? 12 A. Right. So that wouldn't qualify him 13 based on that. Correct. 14 Q. What was his SPO2 after triage? 15 A. Well, this a triage algorithm. So at 16 triage he was 90 percent. This is referring to an 17 SPO2 of less than 90. But I don't know what the 18 number was after his triage. 19 Q. Because he wasn't monitored? 20 A. Because he didn't have a repeated O2 sat 21 done at that point. 22 Q. He was not monitored; correct? 23 A. Well, he was being monitored, yes. He 24 was not on a cardiac or pulse ox monitor.</p>
<p style="text-align: right;">128</p> <p>1 Q. Did Mr. Goode require immediate life- 2 saving intervention under the ESI index? 3 A. It's an interesting index. I've never 4 actually looked at it this closely because it's 5 usually a nursing based treatment. And it must be 6 more of an guideline than an absolute because 7 acute mental status changes could be, you know, 8 anybody who is acutely confused which is half of 9 the drunk and drug intoxicated population in some 10 ERs. So typically a level one would be an acute 11 heart attack, acute stroke, you know, an 12 amputation of an extremity. Typically won't 13 consider him an immediate life-saving intervention 14 type patient. But if you're looking at the words 15 that are in here one could say oh he's an acute 16 mental status change due to his LSD. That's a 17 direct interpretation rather than a use of this 18 which is what the intent is actually meant to be. 19 Q. And that being the case he required 20 immediate life-saving intervention? 21 A. That's what I'm saying I don't think he 22 meets the criteria as these triage scales are 23 typically designed. But, again, I'm not an expert 24 in triage scales or nursing triage.</p>	<p style="text-align: right;">129</p> <p>1 Q. All right. Forget the ESI index. In 2 your opinion did Mr. Goode require emergency 3 medical intervention? 4 A. He required, you know, in the emergency 5 department evaluation and then treatment based on 6 what the evaluation is. He didn't require an 7 immediate intervention until they had a chance to 8 take a look at him. You know, not like a guy 9 rolling in with a stroke or a stemi that's already 10 predefined in the pre-hospital setting. 11 Q. Once he was evaluated and you have seen 12 the evaluation, did he require intervention? 13 A. He -- I guess you'd say he required 14 sedation or intervention, sure. 15 Q. He required supplemental oxygen also; 16 correct? 17 A. I don't believe that he required 18 supplemental oxygen at the time he was being 19 evaluated. He required to be sedated and have a 20 chance for a better reassessment. 21 Q. But the way -- did he require 22 supplemental oxygen five minutes before he ceased 23 breathing? 24 A. Did he require supplemental oxygen five</p>

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<p style="text-align: right;">130</p> <p>1 minutes before when, I missed that?</p> <p>2 Q. That he ceased breathing?</p> <p>3 A. I did not see any indication that he</p> <p>4 required supplemental oxygen at that point either.</p> <p>5 Q. You don't know because there was nothing</p> <p>6 to tell you one way or another; correct?</p> <p>7 A. Well, there was certainly the</p> <p>8 observation that he was still yelling and</p> <p>9 verbalizing and moving air in and out. Typically</p> <p>10 people who are hypoxic can't breathe or focus on</p> <p>11 breathing and not yelling and screaming. So there</p> <p>12 was some objective data that implied that he was</p> <p>13 moving air appropriately. But no O2 sat</p> <p>14 documented, that's the original question.</p> <p>15 Q. And that observation you just mentioned</p> <p>16 came from a police officer?</p> <p>17 A. Came from a police officer. Again, some</p> <p>18 person across the hall said he was making noises</p> <p>19 and was alive, and that other staff were hearing</p> <p>20 him yelling and disrupting the emergency</p> <p>21 department.</p> <p>22 Q. Well, you need to go back and look at</p> <p>23 the deposition, Doctor, because when he was</p> <p>24 yelling breathing he was not -- he was still in</p>	<p style="text-align: right;">131</p> <p>1 the decontamination room not across the hall?</p> <p>2 A. I thought she heard him after she was</p> <p>3 across the hall and through the cracked door. So</p> <p>4 I apologize if I misinterpreted that.</p> <p>5 Q. Do you agree or disagree a patient in</p> <p>6 severe respiratory distress or with an SVO2 of</p> <p>7 less than 90 percent may still be breathing but is</p> <p>8 in need of immediate intervention to maintain an</p> <p>9 airway and oxygenation status. This is the</p> <p>10 patient who will require the physician in the room</p> <p>11 ordering medications such as those used for rapid</p> <p>12 sequence intubation or preparing for other</p> <p>13 interventions for airway and breathing. That's</p> <p>14 from the ESI triage at Page 10. Do you agree or</p> <p>15 disagree with that?</p> <p>16 A. You got me to the right page, sorry.</p> <p>17 Again, I think earlier we talked about the O2 sat</p> <p>18 as an absolute number has to be put into the</p> <p>19 clinical perspective. I see lots of patients who</p> <p>20 come in with O2 sats less than 90 percent who do</p> <p>21 not need to be intubated or intervened because</p> <p>22 that's where they live. And so I think absolutes</p> <p>23 are not part of a standard thing. It's something</p> <p>24 to consider to assess. But I wouldn't agree with</p>
<p style="text-align: right;">132</p> <p>1 it if it's an absolute the way this is written.</p> <p>2 Q. So you disagree with the ESI severity</p> <p>3 index?</p> <p>4 A. If the phrase that says a patient in</p> <p>5 severe respiratory distress or with an O2 sat less</p> <p>6 than 90 percent may still be breathing but is in</p> <p>7 need of immediate intervention to maintain an</p> <p>8 airway and oxygen status. Again, there are</p> <p>9 exceptions to that. So if there is further</p> <p>10 language that tells you to use your clinical</p> <p>11 judgment, this is not a replacement for them, I</p> <p>12 would agree with that. But if it's saying</p> <p>13 everybody who has an O2 sat less than 90 percent</p> <p>14 must be -- is in need of an immediate</p> <p>15 intervention, I would disagree with that based on</p> <p>16 my clinical experience.</p> <p>17 Q. Don't you think it's a good idea if you</p> <p>18 get a reading of 90 percent oxygen saturation that</p> <p>19 you take the same course of action and give</p> <p>20 supplemental objection?</p> <p>21 A. I think you need to look at the clinical</p> <p>22 scenario surrounding that number. One, do you</p> <p>23 believe the number if it's real. If it's real do</p> <p>24 they seem to have any respiratory issues? Are</p>	<p style="text-align: right;">133</p> <p>1 they cyanotic? Are they having difficulty getting</p> <p>2 air in? Are they yelling and screaming? So you</p> <p>3 should take a look at that number with a clinical</p> <p>4 eye. And then if there's things that show that</p> <p>5 there might be a respiratory depression, they're</p> <p>6 not breathing well, they're cyanotic, then you</p> <p>7 might want to consider oxygen. But across the</p> <p>8 board I don't think there is an expectation that</p> <p>9 you immediately put on O2 for somebody who is</p> <p>10 agitated, combative and had an O2 sat reading</p> <p>11 that's 90 percent and may not even be accurate.</p> <p>12 Q. You keep saying -- give me one fact, a</p> <p>13 fact, that says that disproves the 90 percent</p> <p>14 range?</p> <p>15 A. Well, there's --</p> <p>16 Q. One fact?</p> <p>17 A. I'm trying to answer you. You're</p> <p>18 interrupting me again. I apologize for trying to</p> <p>19 be responsive.</p> <p>20 Q. No, you're not trying to answer. What</p> <p>21 you're doing is you're guessing. I want a fact,</p> <p>22 an indisputable fact that the 90 percent reading</p> <p>23 taken by the nurse, that was Mr. Baker, was</p> <p>24 incorrect, one fact?</p>

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<p style="text-align: right;">134</p> <p>1 A. In the record there's a notation where 2 there is a zero heart rate. We know that that 3 fact is inaccurate, because we know he had a heart 4 rate at that time. And so that the monitoring 5 equipment was not accurately measuring, that could 6 be a fact that would support the O2 sat not 7 measuring correctly because the pulse is not 8 matching up.</p> <p>9 Q. Is that it? You say that because the 10 heart rate is recorded as zero that that 11 translates it into the O2 saturation is incorrect; 12 is that your answer?</p> <p>13 A. That's a fact that you requested. And 14 so that would be consistent with the fact that an 15 O2 sat monitor that's not picking up a heart rate 16 correctly may not be picking up the O2 sat 17 completely as well.</p> <p>18 Q. The only fact that could be to disprove 19 the 90 percent is another O2 reading of a 20 different level; correct?</p> <p>21 A. If it's obtainable that would certainly 22 give you another point. But if you keep getting 23 90 percent and zero, you don't keep documenting 24 that. You look at it it's not working and you'll</p>	<p style="text-align: right;">135</p> <p>1 obtain the sat reading later when you have a more 2 calm patient.</p> <p>3 Q. Was that done?</p> <p>4 A. I don't know if they checked it multiple 5 times at the one time they were doing it or not. 6 I don't recall the specifics of their attempt to 7 get that sat.</p> <p>8 Q. Was it done after sedation?</p> <p>9 A. After sedation?</p> <p>10 Q. Sedation.</p> <p>11 A. That was the plan to get him 12 reevaluated. But it was not done until he was 13 actually more calm which unfortunately was the 14 time he went into cardiac arrest.</p> <p>15 Q. What is the gold standard for 16 determining excited delirium in your opinion?</p> <p>17 A. The gold standard? If we're clinically 18 defining it, it's basically assessing the patient 19 clinically, looking at the characteristics, 20 looking at the predisposing factors, we talked 21 about the drugs or psychiatric disorders, 22 assessing for other possible causes, and then it's 23 a clinical based diagnosis. Ultimately, if you 24 want to get beyond that, you can do the Deb Mash</p>
<p style="text-align: right;">136</p> <p>1 study with the brain if it happens to come to it. 2 But from a clinical perspective it's basically 3 looking at the presentation.</p> <p>4 Q. Doctor, you have testified -- you've 5 testified repeatedly that the gold standard was 6 ABG testing?</p> <p>7 A. For excited delirium?</p> <p>8 Q. Arterial blood gas.</p> <p>9 A. I know what that it. But it has nothing 10 to do with defining excited delirium syndrome.</p> <p>11 Q. What does it have to do with it? It 12 deals with the amount of oxygen in the blood; 13 right?</p> <p>14 A. An ABG will give you a partial pressure 15 of oxygen. Correct.</p> <p>16 Q. That's what you have said is the gold 17 standard for terming whether somebody is in 18 asphyxia?</p> <p>19 A. I don't believe I've ever said that.</p> <p>20 Q. You don't?</p> <p>21 A. Is in asphyxia, no. It's a measurement 22 for hypoxia.</p> <p>23 Q. Okay. Is it the gold standard for 24 determining hypoxia?</p>	<p style="text-align: right;">137</p> <p>1 A. It would be the gold standard over an O2 2 sat reading. Yes.</p> <p>3 Q. Was an ABG ordered for Mr. Goode?</p> <p>4 A. I'm assuming you mean prior to his 5 cardiac arrest?</p> <p>6 Q. Well, yeah. That makes sense.</p> <p>7 A. I'm qualifying it because I can't 8 remember if one was ordered later. I did not see 9 an ABG ordered on Mr. -- certainly not performed 10 on Mr. Goode prior to his cardiac arrest. I'd 11 have to double check the orders to see if it was 12 actually ordered.</p> <p>13 Q. And if you had had the -- if Dr. Oliver 14 had ordered that and you had that test result, we 15 would know exactly what his oxygen saturation was, 16 would we not?</p> <p>17 A. If he had ordered it, it was obtained 18 and completed correctly, we would have the partial 19 pressure of oxygen, not his oxygen saturation. We 20 would know what that number is. Yes.</p> <p>21 Q. I'm sorry, I meant to ask we would know 22 whether or not he was hypoxic?</p> <p>23 A. We would have an objective measure for 24 that. Correct.</p>

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<p>1 Q. But we don't have that?</p> <p>2 A. That is correct.</p> <p>3 Q. And that's something that should have</p> <p>4 been done, correct, getting an ABG?</p> <p>5 A. At the time of his acute agitation I</p> <p>6 would say no.</p> <p>7 Q. After he registered a 90 on the pulse</p> <p>8 oximetry, an ABG would have been a real good idea</p> <p>9 to determine whether or not he was hypoxic;</p> <p>10 correct?</p> <p>11 A. If you're talking about ideas versus</p> <p>12 reality, sure an ABG will give you the</p> <p>13 measurement. In the reality that's much harder to</p> <p>14 do than getting an EKG monitor or an IV placed,</p> <p>15 much more unsafe. So the practicality is it's</p> <p>16 absolutely crazy to try to order that in the acute</p> <p>17 setting like this.</p> <p>18 Q. Well, let me read you a quote. And I</p> <p>19 quote, "After adequate physical control is</p> <p>20 achieved, medical assessment should be immediately</p> <p>21 initiated indeed because cardiopulmonary arrest</p> <p>22 might occur suddenly. EMS should be ideally</p> <p>23 present and prepared to resuscitate before</p> <p>24 definitive law enforcement measures are initiated</p>	<p>138</p> <p>1 when possible. Although, the need for control</p> <p>2 measures may take precedence. Initial assessment</p> <p>3 should include vital signs, cardiac monitoring,</p> <p>4 intravenous access, glucose measurement, pulse</p> <p>5 oximetry, and supplemental oxygen, and careful</p> <p>6 physical examination." Agree or disagree?</p> <p>7 A. Well, it should if it's feasible, right.</p> <p>8 That's after the police arrest somebody get him in</p> <p>9 control, that's a paramedic assessment. You're</p> <p>10 doing what you can do. It doesn't mean you're</p> <p>11 going to be successful in doing it. But it's</p> <p>12 certainly all things that should be considered</p> <p>13 based on the physiologic presentation.</p> <p>14 Q. Who wrote that?</p> <p>15 A. I don't know. It could be me for all I</p> <p>16 know.</p> <p>17 Q. It was you. In the Journal of Emergency</p> <p>18 Medicine in 2012 you wrote that; correct?</p> <p>19 A. I'd have to look at it. But it sounds</p> <p>20 like something I could have written, sure.</p> <p>21 Q. And what I read to you is verbatim what</p> <p>22 you wrote about how a patient perceived to be --</p> <p>23 that cardiopulmonary arrest might occur suddenly.</p> <p>24 That's certainly true; right?</p>
<p>140</p> <p>1 A. I agree with that.</p> <p>2 Q. And that these measures should be taken</p> <p>3 which include supplemental oxygen, pulse oximetry,</p> <p>4 cardiac monitoring, glucose measures. You wrote</p> <p>5 that; right?</p> <p>6 A. I just said should be. It's not</p> <p>7 necessarily always feasible or able to be done,</p> <p>8 but sure. In a perfect situation you do all that.</p> <p>9 Q. You know what, in your paper you didn't</p> <p>10 put that qualification in there. You said this is</p> <p>11 what should be done; right?</p> <p>12 A. I didn't --</p> <p>13 Q. You still agree with that?</p> <p>14 A. I haven't read the whole paper and see</p> <p>15 where I qualified it other places or not. But,</p> <p>16 again, the word should is -- it didn't say must or</p> <p>17 requires or has to. It says should. And that's</p> <p>18 implicit that you have to be -- you have to be</p> <p>19 able to do it in order to complete that task.</p> <p>20 Q. All right. Well, let's dissect that.</p> <p>21 You start off by saying after adequate physical</p> <p>22 control is achieved, that's what you're referring</p> <p>23 to, right, getting the patient under control?</p> <p>24 A. Right.</p>	<p>141</p> <p>1 Q. When the EMS arrived on the scene</p> <p>2 Mr. Goode was already hogtied and surrounded by</p> <p>3 four or five or six officers; correct?</p> <p>4 A. That's what I'm trying to recall. But</p> <p>5 that sounds familiar that he was already hogtied</p> <p>6 when they arrived.</p> <p>7 Q. He was not a threat to anyone; correct?</p> <p>8 A. He still has a risk. But he's less of a</p> <p>9 threat being restrained than he was unrestrained.</p> <p>10 Q. Well, if the officers wrote that</p> <p>11 Mr. Goode is no longer a threat he is secure,</p> <p>12 would you agree?</p> <p>13 A. I agree that he --</p> <p>14 MR. HUSKISON: I object to the form of</p> <p>15 that question.</p> <p>16 BY MR. EDWARDS:</p> <p>17 Q. Go ahead.</p> <p>18 A. I agree that if they say he's secure I'd</p> <p>19 have to defer to the expertise in that and not a</p> <p>20 threat. Again, there's nobody who is a zero</p> <p>21 threat. But he's certainly not as much of a</p> <p>22 threat as he was before. He's appropriate to</p> <p>23 assess at that point.</p> <p>24 Q. He was assessed at that point by Richard</p>

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<p style="text-align: right;">142</p> <p>1 Weatherford. Did you read that statement?</p> <p>2 A. I have read the materials earlier. Yes.</p> <p>3 Q. Okay. Did he receive cardiac</p> <p>4 monitoring?</p> <p>5 A. He had a rhythm strip done by the</p> <p>6 paramedic, sure.</p> <p>7 Q. He got intravenous access; right?</p> <p>8 A. He did do that. Yes.</p> <p>9 Q. He didn't get any glucose measurement?</p> <p>10 A. I don't recall one done in the field.</p> <p>11 But I'd have to double check on that.</p> <p>12 Q. Actually, and Mr. Weatherford did pulse</p> <p>13 oximetry but we don't know what it was; correct?</p> <p>14 A. I believe he tried and couldn't get it</p> <p>15 to read.</p> <p>16 MR. HUSKISON: Again, this is Berk</p> <p>17 Huskison. I object to the form.</p> <p>18 BY MR. EDWARDS:</p> <p>19 Q. What's the basis -- the report said he</p> <p>20 did an assessment and he put a pulse oximetry on.</p> <p>21 So what is the basis for your statement that he</p> <p>22 tried and could not get a reading?</p> <p>23 A. That if he had gotten a reading he would</p> <p>24 have documented it.</p>	<p style="text-align: right;">143</p> <p>1 Q. If you don't get a reading, you know</p> <p>2 that you didn't get a reading; correct?</p> <p>3 A. I guess that would make sense. If you</p> <p>4 don't get a reading, you know that. Yes.</p> <p>5 Q. That's what the EMS did throughout that</p> <p>6 report, if they couldn't get a reading they put no</p> <p>7 reading available or words to that effect. You've</p> <p>8 reviewed that; correct?</p> <p>9 A. I'd have to refresh myself to the</p> <p>10 specifics of it. But they do document that way,</p> <p>11 yeah.</p> <p>12 Q. But the pulse oximetry box was blank,</p> <p>13 didn't say couldn't get a reading; correct?</p> <p>14 A. I'd have to relook at that specifically.</p> <p>15 Q. Well, whatever it says it says, you</p> <p>16 agree with that?</p> <p>17 A. Whatever --</p> <p>18 Q. You don't have any information different</p> <p>19 than what's on the EMS report, do you?</p> <p>20 A. Was documented is what's documented.</p> <p>21 Yes.</p> <p>22 Q. All right. Your writing in the Journal</p> <p>23 of Emergency Medicine in 2012 says supplemental</p> <p>24 oxygen is to be given; correct?</p>
<p style="text-align: right;">144</p> <p>1 A. If that's what it says there, sure.</p> <p>2 Q. So that was violated by the EMS and the</p> <p>3 hospital; correct?</p> <p>4 A. It says should and --</p> <p>5 Q. No, it doesn't.</p> <p>6 A. The word should was not in that</p> <p>7 sentence?</p> <p>8 Q. Yes, you're correct. It is in the</p> <p>9 sentence. Should include vital signs. And so</p> <p>10 what does should mean?</p> <p>11 A. Should means if you can do it to try and</p> <p>12 do it. It doesn't mean it's an absolute or a</p> <p>13 must. And if there are reasons not to do it for</p> <p>14 safety purposes or practicality, then that is what</p> <p>15 clinical judgment is for.</p> <p>16 Q. Okay. And so if the EMS could not</p> <p>17 perform the assessment the way it should be done,</p> <p>18 then the hospital should do it; correct?</p> <p>19 A. The assessment of the individual, you</p> <p>20 assess the best you can under the circumstances.</p> <p>21 Both parties EMS and hospitals should be doing the</p> <p>22 best assessment they can.</p> <p>23 Q. Right. If the EMS -- for instance,</p> <p>24 somebody who has not been assessed by EMS then it</p>	<p style="text-align: right;">145</p> <p>1 falls upon the hospital to do the assessment;</p> <p>2 correct?</p> <p>3 A. That's the next level of care. The hand</p> <p>4 off will be there and they will do their typically</p> <p>5 own assessment whether it was done or not by EMS.</p> <p>6 Q. Okay. And you agree that when a patient</p> <p>7 comes in in law enforcement restraints -- law</p> <p>8 enforcement restraints would never be used by a</p> <p>9 hospital personnel; is that correct? Hard</p> <p>10 restraints?</p> <p>11 A. You're talking about handcuffs basically</p> <p>12 or like shackles?</p> <p>13 Q. Yes.</p> <p>14 A. By hospital who, employees?</p> <p>15 Q. Personnel.</p> <p>16 A. Or security. And many security officers</p> <p>17 carry handcuffs to use as necessary. They're not</p> <p>18 a primary source of restraint of somebody as a</p> <p>19 patient.</p> <p>20 Q. I see. So are you not aware that CMS</p> <p>21 says that the use of law enforcement restraints</p> <p>22 are not considered to be safe appropriate health</p> <p>23 care restraint interventions by use by hospital</p> <p>24 staff to restrain patients?</p>

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<p style="text-align: right;">146</p> <p>1 A. You said health care, I think health 2 care something else. You're saying that hospital 3 employees should never use handcuffs basically. 4 And I was saying that there are times where 5 security who are hospital employees do use 6 handcuffs, but not as part of patient care as I 7 believe your CMS commentary is referring to. 8 Q. All right. Are you aware that -- you 9 agree that the hospital is still responsible for 10 appropriate patient assessment in the provision of 11 safe appropriate care to its patient (the law 12 enforcement officer's prisoner). You agree? 13 A. The hospital employees are going to 14 assess and take care of the patient. It seems 15 like a reasonable statement of what they do. Yes. 16 Q. In the notice of deposition we requested 17 that you bring to this deposition any primary 18 responses showing that LSD can cause excited 19 delirium. What have you brought? 20 A. I have brought several articles. The 21 one that I think we referred to earlier, the 22 Ronald O'Halloran, Larry Lewman article from 1993 23 Restraint Asphyxiation and Excited Delirium. 24 Q. While we're on that subject, Doctor, and</p>	<p style="text-align: right;">147</p> <p>1 I will let you go through all of them. On that 2 O'Halloran article was it a reference to footnotes 3 26 and 27 for the proposition of LSD? 4 A. In what article? Twenty-six and twenty- 5 seven out of what article? 6 Q. The O'Halloran article that you just 7 pulled out? 8 A. The O'Halloran article does not have 26 9 or 27 references. I'm not following what you're 10 asking me. 11 Q. Okay. Was the LSD reference by 12 Dr. O'Halloran where the patient jumped out of a 13 second story window was under the influence of 14 LSD? 15 A. I'm rereading this because -- he jumped 16 through a window. He cut himself. Is that -- 17 Q. Yes. That was the LSD reference that 18 Dr. O'Halloran made in conjunction with excited 19 delirium? 20 A. Correct. 21 Q. Where the patient jumped out of a window 22 and was basically killed? 23 A. Screaming obscenities, talking 24 incoherently and spitting.</p>
<p style="text-align: right;">148</p> <p>1 Q. And he was hogtied? 2 A. It took four adults to restrain him and 3 transport him to the hospital emergency room. So 4 he didn't die out of the window. He just got cut 5 going through a window. 6 Q. And subsequently died? 7 A. He -- 8 Q. I'm sorry, go ahead. 9 A. Yeah. He subsequently died, but not 10 from the injuries from his jumping out the window. 11 Q. He was hogtied; correct? 12 A. He was handcuffed behind his back, soft 13 restraints and hogtied. Yes, he was. 14 MR. EDWARDS: Okay. Let's mark that 15 article, Bobbie, as the next one. 16 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 17 WAS MARKED AS EXHIBIT NO. 12 TO THE TESTIMONY OF 18 THE WITNESS AND IS ATTACHED HERETO.) 19 BY MR. EDWARDS: 20 Q. Doctor, go ahead. What else do you 21 have? 22 A. Sure. I have an article by 23 Dr. Takeuchi, Ahern, and Henderson. Excited 24 Delirium review.</p>	<p style="text-align: right;">149</p> <p>1 Q. Yes. And what is it about that article 2 that is responsive to our request showing that LSD 3 can cause excited delirium? 4 A. They note that in their article that LSD 5 can cause excited delirium. 6 Q. You will agree that's not a primary 7 resource because it's not a primary article? 8 A. It's a primary article. It's not a case 9 report if that's what you're asking. It's an 10 article that references LSD as a etiology for 11 excited delirium syndrome. 12 Q. It's anecdotal but it is not a case 13 study as you say? 14 A. Case studies are just -- they report a 15 case. It's not generalized science. It's just 16 what somebody cites, publish and reports. 17 Q. What does Dr. Takeuchi say about LSD and 18 excited delirium? 19 A. Basically that methamphetamine, PCP, and 20 LSD have been reported in a few series, but by far 21 the most prevalent drug of abuse found on 22 toxicology screening was cocaine. 23 Q. Okay, yes. In the reference to the LSD 24 is what he's reporting on somebody else's study or</p>

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<p style="text-align: right;">150</p> <p>1 case note?</p> <p>2 A. It's referring to Dr. O'Halloran's</p> <p>3 paper. Yes.</p> <p>4 Q. So we're going back to Dr. O'Halloran</p> <p>5 where the guy jumped out the window and then</p> <p>6 ultimately died?</p> <p>7 A. Went through a window, yes but did not</p> <p>8 die from the window injury.</p> <p>9 Q. The guy that was hogtied?</p> <p>10 A. Correct.</p> <p>11 Q. Okay.</p> <p>12 MR. EDWARDS: Bobbie, mark that one if</p> <p>13 you will please.</p> <p>14 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>15 WAS MARKED AS EXHIBIT NO. 13 TO THE TESTIMONY OF</p> <p>16 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>17 BY MR. EDWARDS:</p> <p>18 Q. You have something else, Doctor?</p> <p>19 A. I have the ACEP White Paper Report on</p> <p>20 Excited Delirium Syndrome published in 2009.</p> <p>21 Q. Is that yours?</p> <p>22 A. That is where I was with an expert panel</p> <p>23 that published this White Paper. I was part of</p> <p>24 that.</p>	<p style="text-align: right;">151</p> <p>1 Q. And what is the reference --</p> <p>2 MR. EDWARDS: Bobbie, go ahead and mark</p> <p>3 that.</p> <p>4 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>5 WAS MARKED AS EXHIBIT NO. 14 TO THE TESTIMONY OF</p> <p>6 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>7 BY MR. EDWARDS:</p> <p>8 Q. What is the reference in that White</p> <p>9 Paper to LSD?</p> <p>10 A. I'd have to look if there's an actual</p> <p>11 reference. I'm not sure if actually referenced</p> <p>12 each individual aspect. But this is also part of</p> <p>13 the experience and expertise of the panel on</p> <p>14 patients -- people who also have had patients with</p> <p>15 LSD clinically excited delirium diagnosed but</p> <p>16 never wrote a case report up on it.</p> <p>17 Q. Well, typically if physicians have an</p> <p>18 usual case they like to write it up; correct?</p> <p>19 A. Some individuals do. But most doctors</p> <p>20 just treat their patients and go home.</p> <p>21 Q. Well, but that's -- it enhance your</p> <p>22 professional stature to be push accomplished?</p> <p>23 A. It does if you're in academic medicine,</p> <p>24 sure.</p>
<p style="text-align: right;">152</p> <p>1 Q. Well, yeah okay. So can you tell us</p> <p>2 anything about the reference to the white paper to</p> <p>3 LSD and excited delirium?</p> <p>4 A. Well, it just says cases involve</p> <p>5 stimulant abuse most commonly cocaine, though</p> <p>6 methamphetamine, PCP, and LSD have also been</p> <p>7 described.</p> <p>8 Q. Okay. Described where?</p> <p>9 A. Described -- well, in the literature we</p> <p>10 talked about O'Halloran. Although, this is not</p> <p>11 referenced in the actual paper directly, the</p> <p>12 O'Halloran paper is referenced in the list of</p> <p>13 papers reviewed by the task force. And it's also</p> <p>14 been seen by members of the task force but not</p> <p>15 necessarily written up as a case report because</p> <p>16 O'Halloran already wrote it up.</p> <p>17 Q. So all you can tell us about LSD and</p> <p>18 excited delirium is the anecdotal mention by</p> <p>19 Dr. O'Halloran?</p> <p>20 A. And members of the task force.</p> <p>21 Q. Who?</p> <p>22 A. Well, I've seen LSD induced excited</p> <p>23 delirium as one. But I didn't write up a case</p> <p>24 report because there was no need to write up a</p>	<p style="text-align: right;">153</p> <p>1 case report at that time.</p> <p>2 Q. Did the patient die?</p> <p>3 A. That I don't believe so.</p> <p>4 Q. Can you -- do you have anymore articles?</p> <p>5 MR. EDWARDS: Do we mark that on,</p> <p>6 Bobbie.</p> <p>7 THE REPORTER: We did mark that.</p> <p>8 BY MR. EDWARDS:</p> <p>9 Q. Do you have anymore?</p> <p>10 A. Then I have the Wetli chapter excited</p> <p>11 delirium in Forensic Science and Medicine Sudden</p> <p>12 Deaths in Custody.</p> <p>13 Q. And what was Dr. Wetli's reference to</p> <p>14 LSD?</p> <p>15 A. It's probably going to be along a</p> <p>16 similar line if I recall, that it is a cause of</p> <p>17 excited delirium.</p> <p>18 Q. That's a conclusion. What's the fact</p> <p>19 that supports the conclusion?</p> <p>20 A. I'm looking at the paper to find exactly</p> <p>21 where that line was. I apologize for not having</p> <p>22 highlighted it. It says "Today, the entity is</p> <p>23 most common among chronic drug users of stimulant</p> <p>24 drugs such as cocaine and methamphetamine, and</p>

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<p style="text-align: right;">154</p> <p>1 sometimes LSD and phencyclidine abusers." But</p> <p>2 there is no reference noted with that comment</p> <p>3 right there.</p> <p>4 Q. Okay. So that's hardly a primary</p> <p>5 source, is it?</p> <p>6 A. Unless he has seen cases of it, he is</p> <p>7 writing it based on his own primary knowledge of</p> <p>8 it.</p> <p>9 MR. EDWARDS: Mark that please, Bobbie.</p> <p>10 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>11 WAS MARKED AS EXHIBIT NO. 15 TO THE TESTIMONY OF</p> <p>12 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>13 BY MR. EDWARDS:</p> <p>14 Q. Doctor, your position that hogtying and</p> <p>15 places a person prone is without physiological</p> <p>16 effect; correct?</p> <p>17 A. It's clinically insignificant</p> <p>18 physiologically.</p> <p>19 Q. Okay. So the studies in which you have</p> <p>20 participated with Chan and Neuman found there was</p> <p>21 a diminution in respiration but it was clinically</p> <p>22 insignificant; is that right?</p> <p>23 A. If you use measuring ventilation</p> <p>24 properties, pulmonary function testings you can</p>	<p style="text-align: right;">155</p> <p>1 find small changes in that in different positions.</p> <p>2 But physiologically based on O2 sats and end tidal</p> <p>3 CO2 it was not significant or clinically</p> <p>4 significant.</p> <p>5 Q. The first one of these studies that have</p> <p>6 generally been referred to as the Chan studies in</p> <p>7 which you participated was published in 1997?</p> <p>8 A. That is correct. Yes.</p> <p>9 Q. And that is the study that was done for</p> <p>10 the case of Price versus San Diego?</p> <p>11 A. That was the case that initiated the</p> <p>12 desire to look into this area more carefully.</p> <p>13 Q. And tell the jury who funded that study?</p> <p>14 A. The funding to do the study was done by</p> <p>15 the County of San Diego.</p> <p>16 Q. That was the defendant in the Price</p> <p>17 lawsuit; correct?</p> <p>18 A. That was one of the defendants. Yes.</p> <p>19 Q. And the Price lawsuit arose because a</p> <p>20 man in custody of the San Diego Police Department</p> <p>21 who was hogtied died; correct?</p> <p>22 A. I can't remember if was police -- it may</p> <p>23 have been Sheriff's Department. But he did die in</p> <p>24 a hogtie position.</p>
<p style="text-align: right;">156</p> <p>1 Q. So the study that was done by you, Chan,</p> <p>2 and Neuman was used in that litigation to defend</p> <p>3 the claim of the plaintiff; correct?</p> <p>4 A. That's study was used during that</p> <p>5 litigation. Yes.</p> <p>6 THE VIDEOGRAPHER: Counsel, there is</p> <p>7 five minutes left on the disc.</p> <p>8 MR. EDWARDS: You want to switch it now?</p> <p>9 THE VIDEOGRAPHER: Yes, sir, if that's</p> <p>10 possible.</p> <p>11 MR. EDWARDS: Yeah, go ahead.</p> <p>12 THE VIDEOGRAPHER: This concludes media</p> <p>13 number two. We're going off the record. The time</p> <p>14 is 11:30 a.m.</p> <p>15 (WHEREUPON, A BREAK WAS TAKEN AND THE</p> <p>16 PROCEEDINGS CONTINUED AS FOLLOWS:)</p> <p>17 THE VIDEOGRAPHER: Time back on the</p> <p>18 record is 11:35 a.m. This begins media number</p> <p>19 three.</p> <p>20 BY MR. EDWARDS:</p> <p>21 Q. Doctor, now we started talking about the</p> <p>22 1997 Chan study and let's get a little background</p> <p>23 on that to make sure my understanding is correct.</p> <p>24 You and Dr. Neuman were working with Dr. Chan at</p>	<p style="text-align: right;">157</p> <p>1 the time that the County of San Diego funded this</p> <p>2 study; is that correct?</p> <p>3 A. Essentially. Dr. Neuman was the senior</p> <p>4 person on the study. Dr. Chan was the first</p> <p>5 author. He and I were I think chief residents</p> <p>6 when we first started the study and Dr. Neuman was</p> <p>7 one of our mentors.</p> <p>8 Q. Okay. And the study so the jury will</p> <p>9 understand what we're talking about was on the</p> <p>10 effect of restraint position and positional</p> <p>11 asphyxia; is that correct?</p> <p>12 A. Right. Basically looking at the effects</p> <p>13 on pulmonary function testing of patients in</p> <p>14 restraint positions.</p> <p>15 Q. What the County of San Diego asked you</p> <p>16 to study was whether placing someone prone on</p> <p>17 their stomach in a hogtie could cause</p> <p>18 asphyxiation; right?</p> <p>19 A. That's correct.</p> <p>20 Q. Okay. And so that's what they funded.</p> <p>21 They funded this study and you and Dr. Chan and</p> <p>22 Dr. Neuman conducted the study; right?</p> <p>23 A. Basically to objectively evaluate how</p> <p>24 the position affects pulmonary function values.</p>

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<p style="text-align: right;">158</p> <p>1 Yes.</p> <p>2 Q. How many subjects, that is people, did</p> <p>3 you have in the study?</p> <p>4 A. Did you ask how many subjects? You cut</p> <p>5 out there.</p> <p>6 Q. Yes.</p> <p>7 A. Okay. We had 15 subjects enrolled.</p> <p>8 Q. People with asthma were excluded from</p> <p>9 that study?</p> <p>10 A. In this study, yes.</p> <p>11 Q. Were any of the people in that study</p> <p>12 under the influence of drugs?</p> <p>13 A. Not the we're -- not in this study. No.</p> <p>14 Q. And in this study the results were</p> <p>15 ultimately used to defend the City of San Diego</p> <p>16 which allegedly had caused the death of a hogtied</p> <p>17 prisoner; correct?</p> <p>18 A. I think it was County of San Diego. And</p> <p>19 it was used during the trial I believe as data.</p> <p>20 Q. Yeah. And who presented the data was</p> <p>21 Dr. Neuman; right?</p> <p>22 A. Dr. Neuman was an expert in that case.</p> <p>23 Yes.</p> <p>24 Q. For the County of San Diego?</p>	<p style="text-align: right;">159</p> <p>1 A. Correct.</p> <p>2 Q. The accused party; correct?</p> <p>3 A. At least one of the accused parties,</p> <p>4 sure.</p> <p>5 Q. And Dr. Neuman did not disclose that he</p> <p>6 had conducted the study with the funding of the</p> <p>7 County of San Diego; correct?</p> <p>8 A. It's disclosed on the paper here. I</p> <p>9 don't know what he disclosed or talked about in</p> <p>10 trial.</p> <p>11 Q. And, again, your conclusion was that the</p> <p>12 placing of somebody in a prone hogtied position</p> <p>13 while it did decrease to some degree the intake of</p> <p>14 oxygen, it was not clinically significant; is that</p> <p>15 correct?</p> <p>16 A. We didn't say the intake of oxygen. We</p> <p>17 said that there were small measurable differences</p> <p>18 in pulmonary function testing volumes, but it did</p> <p>19 not impact oxygen or carbon dioxide levels.</p> <p>20 Q. So bottom line to the layperson is the</p> <p>21 San Diego Sheriff's Department didn't kill this</p> <p>22 guy, Mr. Price or whoever, by putting him in a</p> <p>23 hogtie prone position bottom line?</p> <p>24 A. Didn't cause asphyxiation.</p>
<p style="text-align: right;">160</p> <p>1 Q. Right. But he died?</p> <p>2 A. He did die. Yes.</p> <p>3 Q. Okay. And you've conducted other</p> <p>4 studies that support that position through the</p> <p>5 years; right?</p> <p>6 A. Correct.</p> <p>7 Q. And it is also correct that you excluded</p> <p>8 -- well, first of all, Troy Goode would have never</p> <p>9 qualified for any of these studies, would he?</p> <p>10 A. Using LSD, no. But if he did not use</p> <p>11 LSD he could have qualified.</p> <p>12 Q. But you have admitted that all of the</p> <p>13 studies, however many there are, do not -- did not</p> <p>14 replicate conditions in the field of a person in</p> <p>15 excited delirium being arrested by the police;</p> <p>16 correct?</p> <p>17 A. I think we acknowledged our limitation</p> <p>18 sections that you cannot exactly reproduce field</p> <p>19 situations including intoxication by drugs.</p> <p>20 Q. So none of your studies -- how many have</p> <p>21 you done?</p> <p>22 A. Probably in this area of research with</p> <p>23 positions and restraints about six I think.</p> <p>24 Q. And none of those replicated the</p>	<p style="text-align: right;">161</p> <p>1 conditions that Troy Goode was in at the time of</p> <p>2 his restraint and arrest; correct?</p> <p>3 A. If you're talking about having LSD</p> <p>4 intoxicated individuals, you are absolutely</p> <p>5 correct.</p> <p>6 Q. You can't recreate the stressors that</p> <p>7 somebody being hogtied and put in a prone position</p> <p>8 by police cause, can you?</p> <p>9 A. Well, the stressors of the position if</p> <p>10 one feels there's stressors, yes. But the idea of</p> <p>11 being arrested and/or resisting and/or being on</p> <p>12 drugs, we can't reproduce that. No.</p> <p>13 Q. Well, there are many more components to</p> <p>14 stressors on a person being arrested than just</p> <p>15 being hogtied and lying there prone; right?</p> <p>16 A. There are other potential stressors,</p> <p>17 sure.</p> <p>18 Q. And those -- you cannot replicate those</p> <p>19 conditions for purposes of your studies?</p> <p>20 A. You can't exactly replicate certain</p> <p>21 aspects of it. Correct.</p> <p>22 Q. Well, what you've -- you have said --</p> <p>23 and actually you know Dr. Spitz?</p> <p>24 A. I do know Dr. Spitz.</p>

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<p style="text-align: right;">162</p> <p>1 Q. You know Werner Spitz?</p> <p>2 A. Werner, yes.</p> <p>3 Q. He takes strong issue with your</p> <p>4 conclusions; correct?</p> <p>5 A. It depends which ones you're referring</p> <p>6 to.</p> <p>7 Q. Well, let me read you -- let me read you</p> <p>8 a bit from Spitz and Fisher's medical legal</p> <p>9 investigation of death. This is an authoritative</p> <p>10 treatise, is it not?</p> <p>11 A. It is a published textbook.</p> <p>12 Q. It's reliable, it's deemed reliable by</p> <p>13 forensic pathologists; correct?</p> <p>14 A. Again, it's as reliable as the authors</p> <p>15 and the editors of that book.</p> <p>16 Q. It's widely used by medical examiners?</p> <p>17 A. I know the medical examiners do use that</p> <p>18 as one of their references, sure.</p> <p>19 Q. Thank you. And Dr. Spitz in talking</p> <p>20 about the Neuman group, which would include you;</p> <p>21 right?</p> <p>22 A. Yes.</p> <p>23 Q. He says, in fact, the Neuman group and</p> <p>24 the conclusion of their study acknowledge that</p>	<p style="text-align: right;">163</p> <p>1 they had not intended to duplicate the conditions</p> <p>2 under which restraint position deaths had</p> <p>3 occurred. Do you agree?</p> <p>4 A. To reproduce all of the conditions --</p> <p>5 certainly some of them like the position, but not</p> <p>6 all of the conditions, sure.</p> <p>7 Q. He continues, deaths on gurney</p> <p>8 mattresses, cushioned car seats, or in a restraint</p> <p>9 position on the ground, and on the floor of police</p> <p>10 cars with a contoured surface may have increased</p> <p>11 the abdominal compression had not been addressed</p> <p>12 in their experiment. Agree or disagree?</p> <p>13 A. Well, some of our experiments were</p> <p>14 actually done on hospital gurneys, so that would</p> <p>15 have addressed that concern particularly. But we</p> <p>16 didn't put people on the contoured floors of the</p> <p>17 back of a police car, that's correct.</p> <p>18 Q. Well, let's talk about that. How long</p> <p>19 did any of your studies last?</p> <p>20 A. Approximately 15 minutes I think was the</p> <p>21 longest duration of somebody in a restraint</p> <p>22 position.</p> <p>23 Q. So if you're correct and I think you're</p> <p>24 right, but even if you're correct that Troy Goode</p>
<p style="text-align: right;">164</p> <p>1 was restrained prone in a hogtie for an hour and a</p> <p>2 half, that would mean he was six times restrained</p> <p>3 as long as anybody in any of your tests; correct?</p> <p>4 A. That would be a correct mathematical</p> <p>5 calculation, sure.</p> <p>6 Q. And it's also correct that in your</p> <p>7 testing you gave people rest periods in between</p> <p>8 the measurements that you took; right?</p> <p>9 A. The 15 minutes would be a constant 15</p> <p>10 minutes in the position. There was no rest period</p> <p>11 there. But if you change position for a different</p> <p>12 measurement, there would be a rest period. Yes.</p> <p>13 Q. Okay. And do you agree with Dr. Spitz</p> <p>14 that the international association of chiefs of</p> <p>15 police vehemently opposes the use of prone</p> <p>16 restraint stating that many deaths have occurred</p> <p>17 of individuals who while in police custody have</p> <p>18 been restrained in this position?</p> <p>19 A. I haven't reviewed the material. I know</p> <p>20 that they recommend at different times of their</p> <p>21 publications putting people on the side position</p> <p>22 thinking that it might be more physiologically</p> <p>23 advantageous. But the reality is those were</p> <p>24 usually done prior to all the research that</p>	<p style="text-align: right;">165</p> <p>1 supported the physiologically trial.</p> <p>2 Q. Well, we'll talk about that. Actually</p> <p>3 there are a number of California EMS's which</p> <p>4 prohibit the hogtied prone position; correct?</p> <p>5 A. I don't know if they prohibit the use by</p> <p>6 paramedics. I don't know if they actually</p> <p>7 prohibit the use by law enforcement because that</p> <p>8 would be outside their jurisdiction.</p> <p>9 Q. Well, of course. But the reason -- and</p> <p>10 Orange County is one; right?</p> <p>11 A. That prohibits EMS providers from</p> <p>12 putting somebody in a hogtied position?</p> <p>13 Q. Yes. Transporting via hogtied prone</p> <p>14 position?</p> <p>15 A. That I don't know. I'd have to look at</p> <p>16 their protocols whether they're allowed to</p> <p>17 transport or not.</p> <p>18 Q. Okay. We'll see if we can pull those</p> <p>19 for you. Now, Doctor, you noted in the first</p> <p>20 study Restraint Position and Positional Asphyxia,</p> <p>21 Chan, et al 1997, "It is possible that our</p> <p>22 subjects -- that had our subjects remained in a</p> <p>23 restraint position for a longer period, we may</p> <p>24 have detected more significant alterations in</p>

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<p style="text-align: right;">166</p> <p>1 respiratory physiology." Is that correct?</p> <p>2 A. You didn't give me a location. I'm</p> <p>3 trying to find it.</p> <p>4 Q. 585.</p> <p>5 A. That looks like what we have written</p> <p>6 there. Yes.</p> <p>7 Q. Now explain that to the jury what that</p> <p>8 means, what that sentence means?</p> <p>9 A. Sure. It means that when you write a</p> <p>10 research paper and publish it in a peer reviewed</p> <p>11 journal, you have to put down limitations of the</p> <p>12 study, and it's part of the intellectual honesty.</p> <p>13 So this really is just referring to the fact that</p> <p>14 we looked at patients out to 15 minutes. And</p> <p>15 that's the limitation of the study. Could there</p> <p>16 be changes further out, could be. But based on</p> <p>17 the data here if you're asking me to interpret it,</p> <p>18 then the answer would be no. But the paper is</p> <p>19 written with the limitation of the 15 minute</p> <p>20 window.</p> <p>21 Q. What you're saying is that you in one</p> <p>22 study -- other studies were for shorter periods of</p> <p>23 time; correct?</p> <p>24 A. There were other studies with shorter</p>	<p style="text-align: right;">167</p> <p>1 periods of time. Yes.</p> <p>2 Q. So the longest period would be 15</p> <p>3 minutes and Troy Goode was at least six times</p> <p>4 that; right?</p> <p>5 A. Yes. Based on the hour and a half it</p> <p>6 would be six times the length.</p> <p>7 Q. And what you're acknowledging in your</p> <p>8 study is that if you left somebody hogtied and</p> <p>9 prone for a longer period, there may have been</p> <p>10 significant alterations in respiratory physiology;</p> <p>11 correct?</p> <p>12 A. Anything is possible. That is what</p> <p>13 we're putting in there. Correct.</p> <p>14 Q. And significant change in alterations in</p> <p>15 respiratory physiology means ability to breathe;</p> <p>16 right?</p> <p>17 A. Significant could be statistically</p> <p>18 significant, meaning you would still see -- we saw</p> <p>19 significant changes in the short period of time</p> <p>20 and our change is not clinically significant. So</p> <p>21 could there be more changes, there could be. It</p> <p>22 doesn't mean it would actually impact the ability</p> <p>23 to breathe or ventilate.</p> <p>24 Q. You don't know, you never tested for a</p>
<p style="text-align: right;">168</p> <p>1 long period -- let me ask this. Did you ever test</p> <p>2 for longer than a 15 minute period?</p> <p>3 A. Nothing that was ever published.</p> <p>4 Correct.</p> <p>5 Q. Did you ever test, publish anything that</p> <p>6 would apply directly to Troy Goode's situation of</p> <p>7 an hour and a half restraint hogtied in prone</p> <p>8 position?</p> <p>9 A. We never had somebody with that</p> <p>10 duration. No.</p> <p>11 Q. You also noted as a qualification to</p> <p>12 this study "It is unlikely that this period of</p> <p>13 exercise would stimulate all of the physiological</p> <p>14 alterations that may occur with struggle and</p> <p>15 agitation. In addition, we did not reproduce the</p> <p>16 effects of trauma or psychological stress that</p> <p>17 often occur with apprehended individuals."</p> <p>18 Did you write that?</p> <p>19 A. Yes, we did.</p> <p>20 Q. Is that accurate?</p> <p>21 A. That's a fair statement based on the</p> <p>22 limitations of the study.</p> <p>23 Q. Now the studies that you relied upon and</p> <p>24 have relied -- you rely upon in this case and have</p>	<p style="text-align: right;">169</p> <p>1 relied upon in all of the cases from Connecticut</p> <p>2 to San Diego and points in between, are your</p> <p>3 studies with Chan and Neuman; correct?</p> <p>4 A. They are part of it. And depending on</p> <p>5 the time -- they're part of my repertoire of</p> <p>6 articles I review and rely on.</p> <p>7 Q. There are a great many articles by</p> <p>8 professionals in the field of forensic pathology</p> <p>9 that disagree with you. You agree with that?</p> <p>10 A. There's a great number? I don't think</p> <p>11 that there's other studies that have disagreed, at</p> <p>12 least not in the great number that you refer to.</p> <p>13 Q. Okay. Well, that's probably a bad word,</p> <p>14 you're right. You are aware of studies that have</p> <p>15 been performed in the prone position by people who</p> <p>16 weren't employed as expert witnesses in court to</p> <p>17 exonerate police; right?</p> <p>18 A. To my knowledge, sure I don't know what</p> <p>19 all their backgrounds are. But I know studies</p> <p>20 were done by other individuals.</p> <p>21 Q. Are you familiar with the Edgcombe</p> <p>22 article Anesthesia in the Prone Position 2008?</p> <p>23 A. Edgeco?</p> <p>24 Q. Edgcombe.</p>

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<p style="text-align: right;">170</p> <p>1 A. I'd to look at it again. Is that one 2 that was used in one of the depositions? I'd have 3 to look in -- 4 MR. EDWARDS: Bobbie, it's number eight 5 on our list. 6 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 7 WAS MARKED AS EXHIBIT NO. 16 TO THE TESTIMONY OF 8 THE WITNESS AND IS ATTACHED HERETO.) 9 BY MR. EDWARDS: 10 Q. Doctor, have you seen this paper before? 11 A. I have seen it at some point. Yes. 12 Q. For the benefit of us all, 13 anesthesiology is another area of medicine which 14 is concerned with the position in which a patient 15 is placed; is that correct? 16 A. They do deal with patient position, yes 17 absolutely. 18 Q. Because it can be dangerous to put 19 somebody under anesthesia when they're prone; 20 right? 21 A. That's a very broad statement. You have 22 to be careful about fluid volume statuses, 23 underlying medical conditions, and position can 24 change that. So you want to be aware of all the</p>	<p style="text-align: right;">171</p> <p>1 circumstances. 2 Q. So your answer is on a broad brush 3 statement is the position that a person is in when 4 under anesthesia can be dangerous; correct? 5 A. It can have physiologic changes that you 6 have to manage. I wouldn't call it dangerous if 7 that's the idea of evaluating and planning? 8 Q. You agree when moving a patient into the 9 prone position an almost universal finding is a 10 decrease in cardiac index? 11 A. Where are you reading that at, I'm 12 sorry? 13 Q. 165. 14 A. Thank you. They certainly write that in 15 there, yeah. 16 Q. And cardiac index measures the amount of 17 blood a person's heart is pumping divided by their 18 body size; correct? 19 A. That is the way the measurement is. 20 Yes. 21 Q. Okay. And continuing on, the problem of 22 IVC -- what is IVC? 23 A. The inferior vena cava. 24 Q. And that's -- is that an artery that</p>
<p style="text-align: right;">172</p> <p>1 pumps blood, that the heart pumps blood through? 2 A. It's a vein that returns blood to the 3 heart. 4 Q. A vein, okay. And Dr. Edgcombe notes 5 that the problem of IVC obstruction is well 6 recognized in the prone position. And that's at 7 167. 8 A. It says the problem with IVC obstruction 9 is well recognized and various methods have been 10 attempted to reduce blood loss including use of 11 local anesthetic infiltration, spinal and epidural 12 anesthesia, and deliberate hypotension. So he 13 does make that comment in the full sentence like 14 that. 15 Q. Okay. And so to put things into 16 perspective, this concept of the dangers of 17 hogtying in a prone position all interplay with 18 heart functioning in your opinion; is that 19 correct? 20 A. The data has been measured on it has not 21 shown that cardiac output, blood pressure, or 22 heart rate are impacted by prone position, which 23 would be the functionality of the heart. 24 Q. So Mr. Goode had no problems with his</p>	<p style="text-align: right;">173</p> <p>1 heart to begin with, we talked about that; 2 correct? 3 A. Nothing that was noted on the autopsy. 4 Correct. 5 Q. And so Dr. Edgcombe, the 6 anesthesiologist, is saying that turning a patient 7 to the prone position has a measurable effect on 8 cardiac -- cardiovascular physiology, the most 9 consistent of which is a reduction in cardiac 10 index. And that's at 168. 11 A. It looks like either -- the best I can 12 tell here without having read the whole paper, his 13 reference seems to be something he's referring to 14 16 patients, reference number 16, which is 15 basically changes with prone position during 16 general anesthesia. So anesthesia itself had some 17 impact on cardiac function. So without going 18 through details of it does it apply in this case, 19 it's hard to say. 20 Q. Okay. Are you looking -- which study 21 are you looking at please? 22 A. The Edgcombe, Anesthesia in Prone 23 Position paper. 24 Q. Well, let me ask it this way, I'm sorry</p>

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<p style="text-align: right;">174</p> <p>1 we had a glitch. Dr. Edgcombe is taking the 2 position -- he's an anesthesiologist and he is 3 written that placing somebody in a prone position 4 affects the heart; agree or disagree? 5 A. He reports that we talked about earlier 6 when moving a position into a prone position an 7 almost universal finding is a decrease in cardiac 8 index, with the next paragraph talking about 9 patients who are under anesthesia. 10 Q. Okay. Right. So as a general 11 proposition would you say you take issue with 12 Dr. Edgcombe, an anesthesiologist? 13 A. As I said earlier, I'd have to look at 14 the paper that it was referencing there. But it's 15 16 patients that are under anesthesia when the 16 positions were changed. And I don't know if these 17 are 90-year-olds with very stiff vessels or 18 80-year-olds, or they're more applicable to 19 younger people with more cardiovascular 20 responsiveness. 21 Q. Okay. Well, look at 168. Dr. Edgcombe 22 says: Obstruction of the IVC, the inferior vena 23 cava is a well recognized complication of prone 24 positioning and is exacerbated by any degree of</p>	<p style="text-align: right;">175</p> <p>1 abdominal compression, leading to decreased 2 cardiac output and increased bleeding, venous 3 stasis, and consequent thrombotic complications. 4 Do you have an opinion one way or another on 5 Dr. Edgcombe's assertion? 6 A. I'll break it down because it's a long 7 sentence if that's okay. Obstruction of the IVC 8 is a well recognized complication of prone 9 positioning and is exacerbated by any degree of 10 abdominal compression. You know, these are cases 11 in which you're operating on people and pushing 12 down. It's a different position because you're 13 actually doing work that creates bleeding 14 disorders or clotting features by adding surgical 15 components to it. Leading to decreased cardiac 16 output -- 17 Q. Excuse me, let me interrupt you, Doctor. 18 Where in that statement is there any statement 19 about a surgical component or pressure on the 20 back? Where? 21 A. In that very statement, there's nothing 22 in that very statement. But he's referring to 23 surgical procedures with anesthesia. 24 Q. Okay. Go ahead. What else do you have</p>
<p style="text-align: right;">176</p> <p>1 to say? 2 A. Then it says leading to decreased 3 cardiac output and increased bleeding. As far as 4 decreased cardiac output, that's been measured in 5 non-surgical patients and has not been shown to be 6 affected. Again, I'm not sure what he is 7 referencing to get that information. But if it's 8 older patients with cardiovascular stiffness, more 9 calcifications, that is certainly a possibility. 10 But in younger otherwise healthy patients similar 11 to Mr. Goode, that data hasn't been demonstrated 12 in the work that I'm aware of. I've -- 13 Q. Let me ask you something. Go ahead, 14 sorry. 15 A. I was trying to finish this, this is a 16 long thing. The increased bleeding, venous stasis 17 and consequent thrombotic complications, again, 18 I'd have to read studies about that how the 19 position would actually lead to increased bleeding 20 unless you're referring to operating on somebody 21 and making cutting aspects that would bleed more. 22 Otherwise, putting somebody in a prone position 23 shouldn't make somebody bleed. 24 Q. Don't you think it's a good idea</p>	<p style="text-align: right;">177</p> <p>1 medically that if there's literature out there 2 that is considered to be peer reviewed which 3 states that placing somebody -- a patient in prone 4 position can affect his heart, that it is wise to 5 avoid prone positioning? 6 A. Well, it says that they also affect 7 their bleeding. And I don't think that's a true 8 fact. So just because it's peer reviewed doesn't 9 mean it's applicable to all patients of all types. 10 Q. Don't you think that when there is 11 reliable literature in medicine saying that the 12 prone position can affect the heart, particularly 13 the inferior vena cava, it is a good idea to avoid 14 placing people in the prone position? 15 A. I would disagree. 16 Q. Yes or no? 17 A. I just said I disagree. 18 Q. You disagree? 19 A. Thank you. 20 Q. You disagree with Dr. Edgcombe. All 21 right. 22 A. I disagree with your statement. 23 MR. EDWARDS: Bobbie, pull out number 24 nine, please.</p>

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<p style="text-align: right;">178</p> <p>1 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 2 WAS MARKED AS EXHIBIT NO. 17 TO THE TESTIMONY OF 3 THE WITNESS AND IS ATTACHED HERETO.) 4 BY MR. EDWARDS: 5 Q. Doctor, are you familiar with this 6 article by Dr. Dharmavaram, et al, from the Loyola 7 University Medical Center entitled Effect of Prone 8 Positioning Systems on Hemodynamic and Cardiac 9 Function During Lumbar Spine Surgery: An 10 Echocardiographic Surgery? 11 A. I have seen the study. Yes. 12 Q. Study, I'm sorry. Okay. Now let me ask 13 you about some of his conclusions or their 14 conclusions. Hemodynamic changes. What are 15 hemodynamic changes by the way? 16 A. Hemodynamic refer to blood based 17 changes, usually referring to blood pressure or 18 heart rate. 19 Q. Okay. And blood of course is what 20 carries the oxygen to the organs, in particular 21 the brain; right? 22 A. That's one of the organs that is 23 perfused. Yes. 24 Q. And the brain is -- oxygen is a oxygen</p>	<p style="text-align: right;">179</p> <p>1 organ, if you will? 2 A. It certainly likes oxygen. Yes. 3 Q. And Dr. Dharmavaram and his colleagues 4 concluded hemodynamic changes occur from supine to 5 prone position. And that's at 1392. Do you agree 6 or disagree? 7 A. I'm taking a look at what they say. So 8 under key points it does say hemodynamic changes 9 from supine to prone positioning. 10 Q. Agree or disagree? 11 A. That's what it says there. 12 Q. Yes. In your professional opinion do 13 you agree or disagree with this conclusion, this 14 finding? 15 A. Under the results they note that there 16 are no intergroup differences in demographics, 17 fluid deficit, baseline hemodynamics or 18 differences from supine to prone position were 19 noted. So it seem to have a contradiction in the 20 results compared to their key point. 21 Q. I see. So in so far as this particular 22 paper is concerned, you find a basis to disagree 23 with those conclusions? 24 A. I'm just saying what they wrote in their</p>
<p style="text-align: right;">180</p> <p>1 paper. And it seems to contradict to some degree 2 this key points. 3 Q. All right. 4 MR. EDWARDS: Bobbie, would you pull out 5 number 10, please. 6 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 7 WAS MARKED AS EXHIBIT NO. 18 TO THE TESTIMONY OF 8 THE WITNESS AND IS ATTACHED HERETO.) 9 BY MR. EDWARDS: 10 Q. Doctor, are you familiar with this 11 Barnett study out of Great Britain? 12 A. Yes. I have seen this before too. 13 Q. And can you tell us if you disagree with 14 the conclusions? 15 A. Their conclusions are their conclusions. 16 I'd have to re-review the details of their study. 17 But looking at -- I'd have to review the details 18 of their study to say whether I truly agree or 19 disagree. There may be some small changes that 20 are there that would be agreeable but may not be 21 physiologically impactful. 22 Q. Well, let's look at their conclusions. 23 And I quote "This study is shown that all three of 24 the prone restraint positions tested imposed</p>	<p style="text-align: right;">181</p> <p>1 pressure onto the anterior chest wall and 2 restricted lung function. You agree or disagree? 3 A. I mean they're laying on their stomach, 4 so there would definitely be some pressure on the 5 chest wall. That's just implicit with the 6 position. As far as their commentary on 7 restricted lung function, that's what I'm trying 8 to look at what they did and what their data were. 9 And based on the data they have in Figure 3 10 compared to a seated position, there are some mild 11 changes that you can measure in the three 12 different positions in pulmonary function testing 13 with the caveat that assuming they had done the 14 pulmonary function testing following American 15 Thoracic Society specifications. So if that's the 16 case, there are some small changes that they 17 measure. 18 Q. I didn't ask you this but a person -- is 19 there a ACLS protocol for addressing 20 supraventricular tachycardia? 21 A. There are ACLS protocols for addressing 22 narrow complex tachycardias. 23 Q. Were any ACLS protocols implemented for 24 Troy Goode?</p>

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<p style="text-align: right;">182</p> <p>1 A. Yes.</p> <p>2 Q. Which one?</p> <p>3 A. The pulmonary -- or pulseless electrical</p> <p>4 activity, the V-fib protocols were implemented in</p> <p>5 him.</p> <p>6 Q. Post coding?</p> <p>7 A. Well, yes. That's when you use it.</p> <p>8 Q. If a patient presents to a hospital to</p> <p>9 an emergency department in supraventricular</p> <p>10 tachycardia, should ACLS protocols be implemented?</p> <p>11 A. If they present in true SVT, then you</p> <p>12 would treat them as per SVT protocols. One of</p> <p>13 them is the ACLS algorithm for narrow complex</p> <p>14 tachycardia.</p> <p>15 Q. Okay. Is there an ACLS protocol for</p> <p>16 tachyarrhythmia?</p> <p>17 A. Tachyarrhythmia is the general category,</p> <p>18 then they break them down I believe to narrow and</p> <p>19 wide complexes.</p> <p>20 Q. Okay. Is there a protocol for</p> <p>21 tachyarrhythmia?</p> <p>22 A. I think I just said I think there's an</p> <p>23 overall protocol. But they tend to break them</p> <p>24 down to the two major categories; tachyarrhythmia</p>	<p style="text-align: right;">183</p> <p>1 with wide complex and tachyarrhythmia with narrow</p> <p>2 complex.</p> <p>3 Q. Did Troy Goode present with either</p> <p>4 wide -- or what was the other complex?</p> <p>5 A. Narrow complex.</p> <p>6 Q. Narrow. Did he present with either of</p> <p>7 those?</p> <p>8 A. He had a narrow complex tachycardia. He</p> <p>9 had a sinus tach.</p> <p>10 Q. Was the ACLS protocol implemented?</p> <p>11 A. To treat the underlying issue for that,</p> <p>12 yes by using sedation. You have a tachyarrhythmia</p> <p>13 that is sinus tach, you would treat the underlying</p> <p>14 etiology.</p> <p>15 Q. The ACLS protocol calls for chemical</p> <p>16 sedation?</p> <p>17 A. Typically if it's a sinus tachycardia it</p> <p>18 falls outside of the true treatment portions of</p> <p>19 the ACLS protocol. And it falls under the</p> <p>20 evaluation portion which is identifying the cause</p> <p>21 and treating that cause.</p> <p>22 Q. Okay.</p> <p>23 MR. EDWARDS: Bobbie, would you pull out</p> <p>24 number 49, please.</p>
<p style="text-align: right;">184</p> <p>1 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>2 WAS MARKED AS EXHIBIT NO. 19 TO THE TESTIMONY OF</p> <p>3 THE WITNESS AND ATTACHED HERETO.)</p> <p>4 MR. GASS: Tim, it would have been nice</p> <p>5 if there was copies of all these exhibits provided</p> <p>6 to all of us today.</p> <p>7 MR. EDWARDS: Well, I don't know who you</p> <p>8 think is going to do it. I'm not going to do it.</p> <p>9 If you want to see these things, Rick, come to the</p> <p>10 deposition.</p> <p>11 MR. GASS: Tim, the rule provides that</p> <p>12 if you're going to have exhibits at a deposition</p> <p>13 you're suppose to have copies. It's common</p> <p>14 courtesy and custom to have copies for opposing</p> <p>15 counsel.</p> <p>16 MR. EDWARDS: We do have copies. We</p> <p>17 have them sitting here in Memphis and we have them</p> <p>18 there in San Diego. You could have gone.</p> <p>19 MR. GASS: All you had to do was send us</p> <p>20 PDFs of them and everybody would have had them.</p> <p>21 MR. EDWARDS: I am not going to go out</p> <p>22 abounds for you because you can't get your ass to</p> <p>23 a deposition, period.</p> <p>24 BY MR. EDWARDS:</p>	<p style="text-align: right;">185</p> <p>1 Q. Okay. Doctor, do you have the adult</p> <p>2 tachycardia with pulse algorithm?</p> <p>3 A. I do. Yes.</p> <p>4 Q. You do?</p> <p>5 A. Yes.</p> <p>6 Q. Okay, sir. Now number one, step one,</p> <p>7 these are sequential; right?</p> <p>8 A. Correct.</p> <p>9 Q. So step one is assess appropriateness</p> <p>10 for clinical condition, heart rate typically equal</p> <p>11 to or greater than 150 beats per minute if</p> <p>12 tachyarrhythmia. Did I read that correctly?</p> <p>13 A. A heart rate typically greater than or</p> <p>14 equal to. Yes, you did.</p> <p>15 Q. And then you go to step number two,</p> <p>16 identify and treat underlying cause. What does</p> <p>17 that mean?</p> <p>18 A. That means if it is -- the</p> <p>19 tachyarrhythmia is a tachycardia caused by drugs</p> <p>20 caused by sepsis, caused by fever, caused by</p> <p>21 shock, caused by trauma, you would treat those</p> <p>22 causes and use your clinical judgment and start</p> <p>23 the treatment that would be indicated for either</p> <p>24 of those types of etiologies.</p>

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<p style="text-align: right;">186</p> <p>1 Q. Okay. And it says maintain patient 2 airway; assist breathing as necessary; right? 3 A. Yes, it does. 4 Q. And how do you do that? 5 A. Basically if they're breathing and 6 they're talking and yelling, you take a look at 7 their airway and make sure it's patent. 8 Q. Okay. And then you give supplemental 9 oxygen if hypoxemic; right? 10 A. That is listed there as an option. Yes. 11 Q. And how do you determine if a person is 12 hypoxemic? 13 A. Either by an O2 sat monitoring or by a 14 blood gas. 15 Q. Okay. Well, we know he didn't get a 16 blood gas. We got an O2 reading of 90 percent. 17 Was Troy hypoxemic? 18 A. I would not have started oxygen on him 19 based on that O2 sat reading. So I would not 20 define him as hypoxemic. He has a low normal O2 21 sat. 22 Q. Low normal? What -- normal is 95 and 23 above; correct? 24 A. No. Normal is -- that's -- the mid</p>	<p style="text-align: right;">187</p> <p>1 range anywhere from 93 to 97. Sort of up higher 2 is higher. And then 90 to 92 is sort of a low 3 normal. Below 90 is what most people will define 4 as hypoxemic. But you'll see different papers 5 referring to different levels depending on how 6 they want to look at the data. 7 Q. Give me one authority for the 8 proposition that 90 is normal -- low normal? 9 A. There are lots of references out there 10 that -- 11 Q. Give me one? 12 A. We've had numbers of studies we talked 13 today that talk about O2 sats greater than 90 14 percent or 90 percent or greater as being 15 considered normal, below that being hypoxic as 16 defined in their method sections. 17 Q. Show me one. We had one that said 93, 18 if it was at 93 you had to start supplementing. 19 The EMS from Mississippi say 90 is mild hypoxia 20 requiring supplemental oxygen. You disagree with 21 that? 22 A. If that's what it says, I'm not going to 23 disagree with what they say. 24 Q. And it says cardiac monitor to identify</p>
<p style="text-align: right;">188</p> <p>1 rhythm, monitor blood pressure, and oximetry. 2 What's involved in a cardiac monitoring? 3 A. Cardiac monitor is placing leads onto 4 the body to try to measure the electrical activity 5 of the heart. 6 Q. And that was not done? 7 A. It was done in the field. It was not 8 done at the hospital. 9 Q. It should have been done in the 10 hospital? 11 A. At some point it should have been done, 12 yes. At some point after he calmed down I think 13 it would be the time to place the cardiac monitor. 14 Yes? 15 Q. Are you familiar with the Parkes and 16 Carson entitled Sudden death during restraint? 17 A. I'm sorry, who is the author on that? 18 MR. EDWARDS: Bobbie, this is our number 19 13. 20 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 21 WAS MARKED AS EXHIBIT NO. 20 TO THE TESTIMONY OF 22 THE WITNESS AND ATTACHED HERETO.) 23 MR. GASS: Can you give us the titles 24 and the names of Exhibit 18 and 19 please.</p>	<p style="text-align: right;">189</p> <p>1 THE WITNESS: Eighteen is the 2 physiologic impact of upper limb position in prone 3 restraint. The lead author is Richard Barnett. 4 Number 19 is the acute -- I'm sorry, the Adult 5 Tachycardia With a Pulse Algorithm put out by the 6 American Heart Association in 2015. 7 MR. GASS: Thank you, Doctor. 8 THE WITNESS: You're welcome. 9 BY MR. EDWARDS: 10 Q. Are you -- my question was, Doctor, have 11 you seen this before? 12 A. I have seen this before. Yes. 13 Q. They did five positions? They tested 14 five positions' right? 15 A. I'm just refreshing myself with the 16 details of it. But that's what it looks like. 17 Yes. 18 Q. Okay. And position five was the one 19 close -- was similar to the hogtied position? 20 A. I'm sorry for the delay, I'm just 21 looking for the methods and they didn't define it. 22 But looks like they have standing -- I'm sorry, 23 there's pictures further back. Position two flat 24 on the floor, supine. Front on the floor, prone.</p>

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<p style="text-align: right;">190</p> <p>1 Number four was prone restraining staff applying 2 body weight to torso sort of a chicken wing. And 3 five is arms and legs restraint in a flexed 4 position. So the four leg lock would be the 5 position there. And that's probably you're right 6 the closest to the position of Mr. Goode. 7 Q. Okay. And then Dr. Parkes and Carson 8 conclude that that position you just described 9 caused the greatest change in forced vital 10 capacity at 137. Is that correct? 11 A. Based on their graph Figure 1 that's 12 showing the FVC as a percentage of position one it 13 is the biggest change, 70 percent of that. So I'm 14 just looking at their methodology. So they 15 measure theirs with a single force maximum 16 exhalation followed by inhalation. That would not 17 be standard practice. That's basically -- that's 18 not meeting American Thoracic Society measurements 19 for reproducibility. But that gives that 20 limitation because it doesn't mean that they gave 21 a best effort in these positions. They are 22 reporting some changes in the FVC and the FEV1 in 23 Positions 4 and 5, the ones with the hands behind 24 the back.</p>	<p style="text-align: right;">191</p> <p>1 Q. In fact, they conclude that restraint 2 positions should be considered a risk factor for 3 sudden death during restraint and that some 4 restraint positions are demonstrated to present a 5 greater risk to the patient and others. And 6 that's at 141. 7 A. They do write that down there. Yes. 8 Q. You take issue with that? 9 A. I take issue with their methodology. I 10 think I already said which can would impact the 11 results and therefore the conclusions from that 12 perspective. And, again, sort of the difference 13 between measurable differences and physiologic 14 differences. They didn't measure end tidal CO2 or 15 O2 sats in these individuals nor checked blood 16 gases. So we don't know if there's any changes in 17 hypoxia or hypercarbia in this population to say 18 that there's actually a risk factor for sudden 19 death. I think that's why I think it's a leap to 20 go to that level. 21 Q. One of the patients in the Parkes and 22 Carson study there was a 57 percent reduction in 23 FEV1 while restrained in the hogtied position? 24 And that's at 140.</p>
<p style="text-align: right;">192</p> <p>1 A. Right. 2 Q. Is that correct? 3 A. Based on their methodology that I sort 4 of quickly looked at -- 5 Q. I think you said -- 6 A. -- it was a single recorded measurement 7 or actually to have valid data you need to have 8 reproducibility of at least three within 10 9 percent. So if they had a bad FEV1 there because 10 it wasn't their baseline but it was just a bad 11 push and they try to reproduce it, you may have 12 seen different numbers. So without the 13 reproducibility this data really isn't -- it's not 14 scientifically valid. It is what it is. But you 15 can't interpret and say that the 57 percent was 16 real because it wasn't reproduced at least twice. 17 Q. Don't you think Dr. Parkes and Carson 18 thought it was real when they recorded it? 19 A. I don't know what they were thinking 20 when they were doing their study. But if they 21 designed it correctly they should have had 22 American Thoracic Society measurements or a local 23 society which is basically reproducing the testing 24 parameters to demonstrate that they are valid</p>	<p style="text-align: right;">193</p> <p>1 numbers. 2 Q. Are you familiar with the Roeggla, 3 R-O-E-G-G-L-A, study on positioning and its effect 4 on respirations that came out of Austria? 5 A. Respiration and cardiovascular 6 parameters, yes I'm familiar with that one. 7 Q. And that study -- 8 MR. EDWARDS: Bobbie, that's number 16, 9 would you pull that out. 10 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 11 WAS MARKED AS EXHIBIT NO. 21 TO THE TESTIMONY OF 12 THE WITNESS AND IS ATTACHED HERETO.) 13 BY MR. EDWARDS: 14 Q. Now Dr. Roeggla and his colleagues I 15 think it was at the University of Vienna concluded 16 that the hobble restraint had a 40 percent 17 reduction in forced vital capacity, is that 18 correct, sir? 19 A. Looking at their data. Where do you see 20 the 40 percent? This is the mini version, so I'm 21 really straining the eyes to take a look at it. 22 But where are you seeing that 40 percent listed? 23 Q. If you'll look under the section on the 24 second page called results it says mean FVC,</p>

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<p style="text-align: right;">194</p> <p>1 that's forced vital capacity; right?</p> <p>2 A. Yes.</p> <p>3 Q. Decreased by 39.6 percent?</p> <p>4 A. Correct.</p> <p>5 Q. What is forced vital capacity?</p> <p>6 A. That's the amount of air you can blow</p> <p>7 out over time.</p> <p>8 Q. Why is that -- that's what is recorded</p> <p>9 when you do a pulmonary function test; right?</p> <p>10 A. That is done through pulmonary function</p> <p>11 testing. Correct.</p> <p>12 Q. And what is the significance of a almost</p> <p>13 40 percent reduction in forced vital capacity?</p> <p>14 A. Same issues with this paper as the other</p> <p>15 one, they didn't reproduce their data. They only</p> <p>16 had six subjects and they misused their other</p> <p>17 equipment, the Portapres device looking at cardiac</p> <p>18 output. So they -- we know that they misused</p> <p>19 their devices. So it made it very difficult to</p> <p>20 interpret the data here. But a 40 percent</p> <p>21 increase -- or decrease if it was factually real</p> <p>22 would be notable. But there's never been a study</p> <p>23 out there that ever saw anything close to these</p> <p>24 numbers. And when you look at the way they</p>	<p style="text-align: right;">195</p> <p>1 presented their data it implies that there is</p> <p>2 something physiologically wrong with the way they</p> <p>3 measure things.</p> <p>4 Q. Well, it's rather amazing that all of</p> <p>5 these other studies have something wrong with</p> <p>6 theirs but yours don't. Don't you find that</p> <p>7 strange?</p> <p>8 A. This here if you look at their O2 sat it</p> <p>9 says 97.67 percent. First of all, let me measure</p> <p>10 that in O2 sat at that level. Secondly, it's with</p> <p>11 a the blood pressure of 85 over 54. Sat probes</p> <p>12 don't tend to pick up that carefully at those</p> <p>13 levels. There's a lot of inherent issues with the</p> <p>14 study. The other pieces they used a Portapres</p> <p>15 measuring device that was -- if you look at the</p> <p>16 company it was not designed to be used for</p> <p>17 changing positions but rather to be used in an ICU</p> <p>18 setting or a prone -- on a bed setting so that</p> <p>19 you can measure changes over time, not changes in</p> <p>20 position from standing to supine to prone. It</p> <p>21 throws off the way the machine reads on your</p> <p>22 finger. So they used the equipment wrong. So</p> <p>23 that's a criticism of this study.</p> <p>24 Q. These guys at the University of Vienna</p>
<p style="text-align: right;">196</p> <p>1 in your opinion don't know what they're doing?</p> <p>2 A. I think it's actually fairly common</p> <p>3 across the board that there were inherent issues</p> <p>4 beyond my own opinion. It's in the community of</p> <p>5 people who do research in this field that there</p> <p>6 were flaws in this study.</p> <p>7 Q. It also show a very large decrease</p> <p>8 actually 37.4 percent of cardiac output; right?</p> <p>9 A. That was measured based on their blood</p> <p>10 pressure. Correct.</p> <p>11 Q. Yes. Okay. That's significant, that's</p> <p>12 clinically significant?</p> <p>13 A. The number is significant. The</p> <p>14 measurement is flawed.</p> <p>15 Q. Right. I understand your position. But</p> <p>16 assuming that the measurement was accurate, 37.4</p> <p>17 percent in cardiac output is very clinically</p> <p>18 significant; correct?</p> <p>19 A. It would be potentially notable in blood</p> <p>20 pressure changes if was the decrease in output</p> <p>21 suddenly, sure.</p> <p>22 Q. A decrease of mean forced vital capacity</p> <p>23 of 39.6 percent is very clinically significant,</p> <p>24 isn't it?</p>	<p style="text-align: right;">197</p> <p>1 A. It could have clinical implications at</p> <p>2 that level that would you note in measuring oxygen</p> <p>3 saturation or CO2.</p> <p>4 MR. EDWARDS: Bobbie, would you pull out</p> <p>5 Exhibit 15 on the list.</p> <p>6 MR. GASS: Is this Exhibit 15 or is this</p> <p>7 your No. 15?</p> <p>8 MR. EDWARDS: My Number 15 the article</p> <p>9 is entitled The cardiopulmonary effects of</p> <p>10 physical restraint in subjects with chronic</p> <p>11 obstructive pulmonary disease from the Clinical</p> <p>12 Forensic Medicine.</p> <p>13 MR. GASS: And is this now going to</p> <p>14 become Exhibit 22.</p> <p>15 THE REPORTER: It is Exhibit 22.</p> <p>16 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>17 WAS MARKED AS EXHIBIT NO. 22 TO THE TESTIMONY OF</p> <p>18 THE WITNESS AND ATTACHED HERETO.)</p> <p>19 BY MR. EDWARDS:</p> <p>20 Q. Have you seen this article, Doctor?</p> <p>21 A. I have. Yes.</p> <p>22 Q. And there were eight subjects with COPD</p> <p>23 placed in the prone, and then the prone restraint</p> <p>24 position to determine whether physical restraint</p>

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<p style="text-align: right;">198</p> <p>1 was harmful to individuals with pulmonary 2 conditions?</p> <p>3 A. Right.</p> <p>4 Q. Is that the purpose of that?</p> <p>5 A. Eight subjects, yes recruited with COPD.</p> <p>6 Q. And of those eight subjects, three could 7 not tolerate the prone position with risk 8 restraints due to a clinical deterioration in 9 symptoms; is that correct?</p> <p>10 A. If I remember correctly, a 67-year-old, 11 a 70-year-old, and a 69-year-old were unable to 12 tolerate that position.</p> <p>13 Q. So the finding of Dr. Meredith and 14 others -- and let's see. Their finding was that 15 for people with a lung condition, specifically 16 COPD, the prone position was harmful?</p> <p>17 A. For elderly people with significant COPD 18 the prone position did have some impact on them. 19 Yes.</p> <p>20 Q. Clinically significant impact; right?</p> <p>21 A. For these three individuals they found 22 some findings on them.</p> <p>23 Q. You I believe in some of your opinions 24 have referred to a study done by Dr. Shimizu,</p>	<p style="text-align: right;">199</p> <p>1 S-H-I-M-I-Z-U. Am I correct on that?</p> <p>2 A. That I referred to that?</p> <p>3 Q. I thought you had. I could be 4 incorrect.</p> <p>5 A. I think that may have been one of the 6 other experts in this case may have referred to it 7 and I took a look at it.</p> <p>8 Q. Dr. Shimizu --</p> <p>9 MR. EDWARDS: Did I give you the number 10 on that, Bobbie?</p> <p>11 THE REPORTER: No, you didn't.</p> <p>12 MR. EDWARDS: Number 14.</p> <p>13 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 14 WAS MARKED AS EXHIBIT NO. 23 TO THE TESTIMONY OF 15 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>16 BY MR. EDWARDS:</p> <p>17 Q. Got it, Doctor?</p> <p>18 A. I do. Thank you.</p> <p>19 Q. Have you ever seen this article?</p> <p>20 A. I have seen this article before. Yeah.</p> <p>21 Q. And Dr. Shimuzu and et al, in 2014 22 concluded that prone positioning induces 23 significant changes in systolic and diastolic 24 function as well as dyssynchrony; right?</p>
<p style="text-align: right;">200</p> <p>1 A. They do write that --</p> <p>2 Q. Cardiac changes from switching from the 3 supine to prone position?</p> <p>4 A. They do write that in their conclusions.</p> <p>5 Q. Do you disagree with that?</p> <p>6 A. Well, I think that they're looking at 7 several different groups there. So in the group 8 that sort of represented our case here there was 9 no significant changes. But in other groups that 10 had history of heart attacks or ischemic heart 11 disease without myocardial infarction they did 12 find some changes.</p> <p>13 Q. Well, actually at Page 3 of 3 they 14 indicate in all 90 patients in the study heart 15 rate increased and stroke volume index decreased 16 with prone positioning resulting in a decrease of 17 cardiac index, cardiac function was switching 18 supine to prone position. So it says that all 90 19 patients there was a change in the heart rate 20 cardiac index?</p> <p>21 A. The heart rate they said in Group A went 22 from 78 beats per minute to 76 beats per minute. 23 So that would be a change, certainly noting 24 clinically significance. And --</p>	<p style="text-align: right;">201</p> <p>1 Q. All these articles we've been talking 2 about are negative on placing patients in a prone 3 position; is that correct?</p> <p>4 A. Again, this is -- if you're referring to 5 people with history of heart attacks and ischemic 6 heart disease, they have some changes they note. 7 The normal group really does not have anything 8 that would be clinically significant that would be 9 negative towards doing it. But they do note that 10 there are changes that you can measure in these 11 positions. But they don't talk about the 12 physiologic impacts of them.</p> <p>13 Q. Well, actually this Shimuzu study just 14 says prone positioning induces significant changes 15 in systolic and diastolic function as well as 16 dyssynchrony. What is dyssynchrony?</p> <p>17 A. The heart -- the beating of the heart 18 left to right.</p> <p>19 Q. Okay. Then that doesn't qualify the 20 study group, does it? They said this happens in 21 all 90 that they studied.</p> <p>22 A. But the numbers that they report showing 23 their changes are comparing all patients -- well, 24 they compare supine to prone. The numbers are</p>

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<p style="text-align: right;">202</p> <p>1 certainly not anything clinically significant.</p> <p>2 The heart rate change of six beats is hardly</p> <p>3 measurable. Stroke volume indexes between 30 and</p> <p>4 35 are normal. So there's nothing there that</p> <p>5 would be irregular. There's difference you can</p> <p>6 measure them, but nothing that was clinically</p> <p>7 significant in the normal population. So they're</p> <p>8 noting the changes. They're reporting that. But</p> <p>9 it doesn't show any clinical significance for the</p> <p>10 population in these normal groups. It's just</p> <p>11 telling you patients who have other medical</p> <p>12 histories may have some changes. Even there those</p> <p>13 are not dramatic, but they're notable. And that's</p> <p>14 what they're doing.</p> <p>15 Q. Well, it doesn't do much -- add much to</p> <p>16 medical knowledge to report insignificant changes</p> <p>17 from one position to another, does it?</p> <p>18 A. I think it adds a lot of data. Any</p> <p>19 study that shows changes or no changes if done</p> <p>20 scientifically well is helpful for the medical</p> <p>21 community.</p> <p>22 Q. Okay. And in that regard all of these</p> <p>23 articles that we've been reviewing all note</p> <p>24 adverse changes whether clinically significant or</p>	<p style="text-align: right;">203</p> <p>1 not as a result of the prone position; right?</p> <p>2 A. That's what I'm saying I don't agree</p> <p>3 with that. You know, heart rate from 70 to 76,</p> <p>4 one could argue the supine position lowers your</p> <p>5 heart rate. Again, those types of number changes</p> <p>6 though statistically significant in reporting</p> <p>7 don't mean that there's actually some clinical</p> <p>8 significance behind it. And that is an adverse</p> <p>9 effect of the position.</p> <p>10 Q. Doctor, let's switch gears once again.</p> <p>11 A. Do you mind if I ask a quick question</p> <p>12 just for my own planning.</p> <p>13 Q. All right.</p> <p>14 A. How long do you anticipate this going on</p> <p>15 just because I blocked out the four hours you paid</p> <p>16 me for, but I wanted to make sure I let people</p> <p>17 know for things I'm pushing off. Just an idea,</p> <p>18 not a push.</p> <p>19 Q. I think that we are moving towards a</p> <p>20 conclusion. Another 45 minutes maybe.</p> <p>21 A. Okay.</p> <p>22 Q. Of course it depends on your cohorts</p> <p>23 there.</p> <p>24 A. Sure.</p>
<p style="text-align: right;">204</p> <p>1 Q. You have previously testified that only</p> <p>2 approximately 10 percent of individuals suffering</p> <p>3 from excited delirium will die; is that correct?</p> <p>4 A. Yeah. Ten, eleven percent. It's in</p> <p>5 that range, yes.</p> <p>6 Q. And you wrote in excited delirium</p> <p>7 syndrome etiology identification and treatment and</p> <p>8 current practice in forensic medicine. Was that</p> <p>9 last year that you wrote that?</p> <p>10 A. To be honest I'd have to look at the</p> <p>11 reference to determine. I think it was a little</p> <p>12 longer than that. It may have been a few years.</p> <p>13 Q. Can you see this? Is this it?</p> <p>14 A. A textbook. I thought you were</p> <p>15 referring to a binded book. But that still may</p> <p>16 have been a little longer. It may have been</p> <p>17 published last year.</p> <p>18 Q. Okay. So you were contributed. It says</p> <p>19 Gary Vilke and Jason Payne-James wrote on excited</p> <p>20 delirium syndrome etiology identification and</p> <p>21 treatment. That was you?</p> <p>22 A. That's fair, yes.</p> <p>23 Q. Okay. And you relied upon a study by</p> <p>24 Dr. Stratton in 2001 entitled Factors Associated</p>	<p style="text-align: right;">205</p> <p>1 With Sudden Death of Individuals Requiring</p> <p>2 Restraint for Excited Delirium. Is that correct?</p> <p>3 A. That would probably be one of the</p> <p>4 references in there, sure.</p> <p>5 MR. EDWARDS: Let me get a number on</p> <p>6 that. Bobbie, this is 43.</p> <p>7 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>8 WAS MARKED AS EXHIBIT NO. 24 TO THE TESTIMONY OF</p> <p>9 THE WITNESS AND ATTACHED HERETO.)</p> <p>10 MR. GASS: Would you somebody give us</p> <p>11 the exhibit number and the title slowly please.</p> <p>12 THE WITNESS: Exhibit 24 Factors</p> <p>13 Associated with Sudden Death of Individuals</p> <p>14 Requiring Restraint for Excited Delirium. Lead</p> <p>15 author is Samuel Stratton. And it appears to be</p> <p>16 in the American Journal of Emergency Medicine,</p> <p>17 Volume 19, May 2001.</p> <p>18 MR. GASS: Thank you, Doctor.</p> <p>19 THE WITNESS: You're welcome.</p> <p>20 BY MR. EDWARDS:</p> <p>21 Q. Doctor, so that study conducted in LA</p> <p>22 County involved people in police custody who had</p> <p>23 been -- who were in a excited delirium state and</p> <p>24 required hobble restraint; is that correct?</p>

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<p style="text-align: right;">206</p> <p>1 A. That sounds correct. I'm about to look 2 at the details. But they were restrained by 3 police to be transported by paramedics. 4 Q. They were in hogtie restraint; right? 5 A. I'm looking to see if all of them were. 6 I know some of them were. 7 Q. Well, at Page 188 in Dr. Stratton's 8 paper he says all -- well, no, I'll correct 9 myself. There were 214 individuals in 10 Dr. Stratton's study in Los Angeles County; right? 11 A. I'm reading 216 restrained excited 12 delirium victims encountered during the study, all 13 had been in restrained some form of hobble 14 restraint, either loosely (TARP) or tightly 15 (hogtied). The TARP technique was used almost 16 exclusively after 1996. 17 Q. Okay. Of that population of 216, 18 18 individuals died? 19 A. There were 18 deaths. I think 18 deaths 20 were in cardiac arrest while being transported. 21 Q. Okay. And those 18 deaths are all 22 people restrained in the hogtie for excited 23 delirium. And that's at 188; right? 24 A. It was surely the hobble restraint. So</p>	<p style="text-align: right;">207</p> <p>1 hogtie implies being close to the hands. It could 2 be loose where there's more movement with the 3 legs. But the legs were bound and attached to 4 some level. 5 Q. Okay. So of the 18 people who died in 6 Dr. Stratton's study in LA County, all were 7 similarly restrained to the restraint used on Troy 8 Goode? 9 A. It appears they were of similar 10 positioning, sure. 11 Q. And these were all people described as 12 being in a state of excited delirium as that which 13 you have attributed to Mr. Goode's state; correct? 14 A. That is the physiologic presentation of 15 these as well as Mr. Goode. Yes. 16 Q. Okay. So we got 216 people in LA County 17 being studied by Dr. Stratton in regards to police 18 restraints. And 18 of those people died. Am I 19 right so far? 20 A. I can't determine the details. I think 21 18 went into cardiac arrest and died during 22 transport. I'm not exactly sure if they actually 23 followed everybody through hospitalization. But 24 of the ones that happened these happened during</p>
<p style="text-align: right;">208</p> <p>1 transport and died. 2 Q. And all sudden death victims, the 18 in 3 the series had been hobble restrained; correct? 4 A. In some form of hobble restraint, yes. 5 Uh-huh (affirmative response). 6 Q. That's at 188. So that's LA County. 7 And the Stratton study upon which you referenced 8 in your publication on excited delirium syndrome 9 etiology identification and treatment; right? 10 A. I believe it's referenced in there. I 11 didn't double check. But I believe it's in there 12 if you told me. 13 Q. Okay. Two years ago, two years ago, you 14 participated in a study on police restraints in 15 Canada; is that correct? 16 A. I certainly was participating in a prone 17 restraint study up there. I'm not sure which one 18 you're referring to. But I know I've worked with 19 the Canadians on some of their restraints. 20 Q. Restraint in police use of force events. 21 Hall, et al, 2015. 22 A. Yes. That sounds familiar. 23 Q. Okay. I'll get you a copy of it. 24 MR. EDWARDS: Bobbie, this is number 44.</p>	<p style="text-align: right;">209</p> <p>1 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT 2 WAS MARKED AS EXHIBIT NO. 25 TO THE TESTIMONY OF 3 THE WITNESS AND IS ATTACHED HERETO.) 4 BY MR. EDWARDS: 5 Q. Now this study was published in the 6 Journal of Forensic and Legal Medicine. Is that 7 correct, Doctor? 8 A. That is correct. 9 Q. Okay. And you're listed as one of the 10 authors; right? 11 A. I am. 12 Q. Okay. So in this study in Canada, you 13 had more than double the amount of individuals 14 being studied than Dr. Stratton had had in LA 15 County, California; right? 16 A. I mean, which part of this study are you 17 talking about total consecutive use of force 18 events and how many were in prone and not prone 19 positions? 20 Q. Fair enough. I'll rephrase it. In the 21 Canadian study you found that 499 individuals had 22 three or more features of excited delirium? 23 A. Yes. Correct. 24 Q. And 86 individuals had six or more</p>

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<p style="text-align: right;">210</p> <p>1 features of excited delirium?</p> <p>2 A. I think that is correct as well.</p> <p>3 Q. And so out of this population of almost</p> <p>4 600 people, you had one death; is that correct?</p> <p>5 A. There was one death in this population.</p> <p>6 Correct.</p> <p>7 Q. And the one death in this population was</p> <p>8 due to cocaine toxicity; correct?</p> <p>9 A. That sounds familiar. Yes.</p> <p>10 Q. And the one individual who died from</p> <p>11 cocaine toxicity was hyperthermic; correct?</p> <p>12 A. I'd have to look at the details. I know</p> <p>13 he was not prone. But I'd have to check if he was</p> <p>14 hyperthermic. Yes. He had hyperthermia as well.</p> <p>15 Q. So I think I was wrong on my number. I</p> <p>16 think that the group that you were studying was</p> <p>17 closer to 500 than 600. And so out of the 500</p> <p>18 there was one death -- and these were all people</p> <p>19 in Canadian police custody; right?</p> <p>20 A. Correct.</p> <p>21 Q. Okay. And so out of the approximate 500</p> <p>22 people you had one death that was due to cocaine</p> <p>23 toxicity and hyperthermia; right?</p> <p>24 A. That's correct.</p>	<p style="text-align: right;">211</p> <p>1 Q. Now, Doctor, tell the jury how many</p> <p>2 people in the Canadian study were hogtied?</p> <p>3 A. I'd have to read through this. If you</p> <p>4 can point me in the direction it's in there if you</p> <p>5 know it, great. But I can't recall off the top of</p> <p>6 my head if it's even reported in there.</p> <p>7 Q. Doctor, you know that zero of the</p> <p>8 Canadians were hogtied, none; correct?</p> <p>9 A. Well, that's what I'm looking for. I</p> <p>10 don't remember specifically. So to say I know is</p> <p>11 sort of unfair. I'm not recalling, so I'm reading</p> <p>12 through it.</p> <p>13 Q. Page 34, Section 5.5.</p> <p>14 A. It says there, yes. Unlike other</p> <p>15 cohorts no individual in our cohort had ankle</p> <p>16 and/or leg restraints connected in a hogtied</p> <p>17 fashion (also known as the position of maximal</p> <p>18 restraint).</p> <p>19 Q. And the reason that is is the entire</p> <p>20 country of Canada bands hogtying by police;</p> <p>21 correct?</p> <p>22 A. I don't know if that's really the case.</p> <p>23 I don't know their policies up there.</p> <p>24 Q. Well, you went up to study the police</p>
<p style="text-align: right;">212</p> <p>1 practices; right?</p> <p>2 A. I actually worked with the authors to</p> <p>3 evaluate the data, not necessarily to study the</p> <p>4 police practices aspect of it.</p> <p>5 Q. So what we have in contrast is we have a</p> <p>6 study by Dr. Stratton in Los Angeles upon which</p> <p>7 you rely in your writings that dealt with 214</p> <p>8 people, and of those 18 died and everyone was</p> <p>9 hogtied; correct?</p> <p>10 A. They were hobbled or hogtied.</p> <p>11 Q. Yes. And then you contrast that to</p> <p>12 Canada in the study in which you participated for</p> <p>13 the Canadian police that dealt with a much larger</p> <p>14 population about 500, and there were no deaths;</p> <p>15 correct?</p> <p>16 A. If you're talking about -- the 500</p> <p>17 subjects are with three signs of excited delirium</p> <p>18 or more. Typically you would define it the</p> <p>19 tighter definition. You're really looking for</p> <p>20 excited delirium of six or more features. And</p> <p>21 that's a smaller population, but it looks like 86</p> <p>22 patients as well of none of which were hobbled or</p> <p>23 hogtied like you said.</p> <p>24 Q. So we've got hogtying in the U.S. that</p>	<p style="text-align: right;">213</p> <p>1 results in deaths; right? And we've got Canada</p> <p>2 which doesn't allow hogtying, and we've got no</p> <p>3 deaths in the study; right?</p> <p>4 A. Well, again, I don't know if Canada does</p> <p>5 not allow it. You put that into the question</p> <p>6 there. So I can't agree with the whole statement.</p> <p>7 But there were only one death in the population of</p> <p>8 Canada out of the 86 patients with six or more</p> <p>9 features. And as you pointed out the Stratton</p> <p>10 study showed that there were the 18 deaths in the</p> <p>11 population who had the restraints placed.</p> <p>12 Q. This were no deaths in Canada that were</p> <p>13 caused by hogtie; correct?</p> <p>14 A. In this study that would be correct.</p> <p>15 Q. So how do you explain the fact that in</p> <p>16 the U.S. where police hogtie and we got 18 deaths</p> <p>17 among if you say 86 people, and in Canada where we</p> <p>18 got 500 and we don't have any deaths, how do you</p> <p>19 explain that?</p> <p>20 A. Certainly it could be different types of</p> <p>21 evaluations of the data, types of drugs being</p> <p>22 used, populations being studied. Those are all</p> <p>23 things that happen with epidemiologic studies</p> <p>24 trying to compare one cohort to another. So just</p>

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<p style="text-align: right;">214</p> <p>1 to take one study and compare it to another study</p> <p>2 and say all things are equal, scientifically you</p> <p>3 can't do that. But it's something worth taking a</p> <p>4 closer look at at some point if you can get a</p> <p>5 study population to compare with.</p> <p>6 Q. Well, Doctor, the Canadian study is one</p> <p>7 which you designed and participated in?</p> <p>8 A. I participated in it. I didn't actually</p> <p>9 design the methodology. I helped the Canadians</p> <p>10 evaluate their data once they collected it through</p> <p>11 the police department.</p> <p>12 Q. It was your study at least in part;</p> <p>13 right?</p> <p>14 A. I just said that. Yes.</p> <p>15 Q. And Dr. Stratton who did the LA study</p> <p>16 was somebody you whom you put faith because you</p> <p>17 accepted his numbers?</p> <p>18 A. I report what he reported, sure.</p> <p>19 Q. So we got 18 deaths in hogtying in LA</p> <p>20 County, and none in Canada in a much larger</p> <p>21 population. And my question is how do you -- you</p> <p>22 know what Occam's razor is?</p> <p>23 A. I do.</p> <p>24 Q. What's the Occam's razor answer to this</p>	<p style="text-align: right;">215</p> <p>1 question?</p> <p>2 A. That the excited delirium syndrome</p> <p>3 killed the people at both sites because that's the</p> <p>4 only common thing that's going on with them.</p> <p>5 There's no hogtie up there and somebody died.</p> <p>6 There's 18 down here and all of them had excited</p> <p>7 delirium syndrome, not all of them had a hogtie.</p> <p>8 Q. Wrong. Down here in Dr. Stratton's</p> <p>9 study everyone was hogtied?</p> <p>10 A. Correct. You asked me the Occam's razor</p> <p>11 which means you come up with a single diagnosis</p> <p>12 that covers for all the findings. The only thing</p> <p>13 that was across the board in all 19 deaths was the</p> <p>14 fact that they had a state of excited delirium</p> <p>15 syndrome. Eighteen of them happen to be hogtied.</p> <p>16 But the only thing that covers all 19 is the</p> <p>17 excited delirium presentation.</p> <p>18 Q. It was cocaine in Canada that caused the</p> <p>19 death; right?</p> <p>20 A. Cocaine was involved in the excited</p> <p>21 delirium etiology in that one case, sure.</p> <p>22 Q. And cocaine is by far in a way the</p> <p>23 precipitant of the excited delirium that you say</p> <p>24 results in death; correct?</p>
<p style="text-align: right;">216</p> <p>1 A. Cocaine is the more common drug along</p> <p>2 with methamphetamine that causes excited delirium.</p> <p>3 Q. It's a stimulant, it's a highly potent</p> <p>4 stimulant; correct?</p> <p>5 A. Cocaine is, yes.</p> <p>6 Q. LSD is not; correct?</p> <p>7 A. I think we went through that. It has</p> <p>8 some stimulating qualities. But it's classified</p> <p>9 as a hallucinogen.</p> <p>10 Q. But your information is all anecdotal</p> <p>11 because you have not studied LSD?</p> <p>12 A. I have studied about LSD as part of my</p> <p>13 training in emergency medicine. But I have not</p> <p>14 studied LSD as an individual topic as part of my</p> <p>15 research.</p> <p>16 Q. So let me ask you a different question.</p> <p>17 Since the rate -- how many characteristics of</p> <p>18 excited delirium did Troy Goode have in your</p> <p>19 opinion?</p> <p>20 A. He had I believe at least six of them.</p> <p>21 He had violent behavior. He had tolerance to</p> <p>22 pain, consistent physical activity, not responding</p> <p>23 to police presence. He was defined as having</p> <p>24 human strength, rapid breathing, did not tire</p>	<p style="text-align: right;">217</p> <p>1 despite physical activity. He was sweating. He</p> <p>2 had a etiology and he was delusional. So all</p> <p>3 those things would be well over that six mark.</p> <p>4 Q. Okay. So in the Canadian study in which</p> <p>5 you participated there were 86 persons with six or</p> <p>6 more markers or characteristics; right?</p> <p>7 A. Correct.</p> <p>8 Q. As with Troy Goode; right?</p> <p>9 A. Correct.</p> <p>10 Q. So in taking Dr. Stratton's percentage</p> <p>11 that you relied upon 10 percent of 86 or between</p> <p>12 eight and nine people statistically should have</p> <p>13 died?</p> <p>14 A. Correct.</p> <p>15 Q. From excited delirium?</p> <p>16 A. If you used Sam Stratton's numbers</p> <p>17 extrapolate across that population, that should be</p> <p>18 eight or nine. Correct.</p> <p>19 Q. Well, you did. You used his numbers;</p> <p>20 right?</p> <p>21 A. I reported his numbers as the time the</p> <p>22 epidemiologic best numbers that we could tell for</p> <p>23 patients exhibiting those signs. You know, 11</p> <p>24 percent went into cardiac arrest based on his</p>

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<p style="text-align: right;">218</p> <p>1 data.</p> <p>2 Q. So let's take a break now. I'll get my</p> <p>3 notes together and maybe we can wrap up, okay.</p> <p>4 A. Sounds great. Thank you.</p> <p>5 THE VIDEOGRAPHER: Time off the record</p> <p>6 is 1:02 p.m. This ends media number three.</p> <p>7 (WHEREUPON, A BREAK WAS TAKEN AND THE</p> <p>8 PROCEEDINGS CONTINUED AS FOLLOWS:)</p> <p>9 THE VIDEOGRAPHER: Time back on the</p> <p>10 record is 1:09 p.m. This begins media number</p> <p>11 found. Counsel, you may proceed.</p> <p>12 MR. EDWARDS: Bobbie, would you pull our</p> <p>13 number 32, please.</p> <p>14 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>15 WAS MARKED AS EXHIBIT NO. 26 TO THE TESTIMONY OF</p> <p>16 THE WITNESS AND ATTACHED HERETO.)</p> <p>17 THE WITNESS: For those on the phone it</p> <p>18 looks like it's the National Association of State</p> <p>19 EMS Officials, National Model EMS Clinical</p> <p>20 Guidelines, Exhibit 26.</p> <p>21 BY MR. EDWARDS:</p> <p>22 Q. Are you a member of that association?</p> <p>23 A. National Association of State EMS</p> <p>24 Officials, I am not.</p>	<p style="text-align: right;">219</p> <p>1 Q. You're familiar with these Model EMS</p> <p>2 guidelines?</p> <p>3 A. I am not familiar with these either.</p> <p>4 No.</p> <p>5 Q. Well, turn over to Page 46. And if you</p> <p>6 will please take a minute and read to yourself the</p> <p>7 patient safety considerations.</p> <p>8 A. Okay.</p> <p>9 Q. Are there -- there are one through</p> <p>10 twelve points in this section. Are there any of</p> <p>11 these with which you disagree?</p> <p>12 A. Disagree versus style I think is your</p> <p>13 question. I don't disagree with any of them. But</p> <p>14 I don't think that all of them are absolute. It</p> <p>15 says patient should never be transported while</p> <p>16 hobbled, restrained, or restrained in a prone</p> <p>17 position with hands and feet behind the back.</p> <p>18 That's their opinion. I think that there are</p> <p>19 circumstances where that's sometimes the safest</p> <p>20 way to transport somebody.</p> <p>21 And so I'm not a big fan of the never</p> <p>22 aspect of a recommendation or guideline. The</p> <p>23 absolutes always make me uncomfortable where I</p> <p>24 would tend to disagree with that type of a thing.</p>
<p style="text-align: right;">220</p> <p>1 Otherwise, you know, patients who have received</p> <p>2 anti-psychotic medication as a chemical restraint</p> <p>3 must be monitored closely for the potential</p> <p>4 development of. You can't measure somebody for</p> <p>5 ataxia because they're restrained. Ataxia is an</p> <p>6 ambulatory issue. So some of these things are</p> <p>7 sort of -- sort of odd to be in a thing.</p> <p>8 But in and of itself it's a reasonable</p> <p>9 set of things to think about for taking care of</p> <p>10 somebody who is agitated. But, again, I'm not a</p> <p>11 fan of the never and always type of comments.</p> <p>12 Q. Well, the reason that -- the reason that</p> <p>13 they have here never transport while hobbled or</p> <p>14 hogtied or restrained in a prone position is a</p> <p>15 patient safety consideration; right?</p> <p>16 A. It is intended to be a safety</p> <p>17 consideration but often times will create more</p> <p>18 problems trying to switch somebody from a hogtie</p> <p>19 position to a non-hogtie position from a scene</p> <p>20 safety as well as an individual safety of the</p> <p>21 patient perspective.</p> <p>22 Q. Well, what is it that you say prevented</p> <p>23 Troy Goode from being taken off his stomach and</p> <p>24 put on his side or restrained in four point</p>	<p style="text-align: right;">221</p> <p>1 restraints on the stretcher, what prevented that?</p> <p>2 A. They had been trying to put him on his</p> <p>3 sides a number of times earlier by the paramedic</p> <p>4 reports and he kept wobbling back and forth and</p> <p>5 spitting and twisting so that he wouldn't stay on</p> <p>6 his side. At the hospital the degree of agitation</p> <p>7 and behavior would potentially create more harm to</p> <p>8 try to switch him out than to just give some</p> <p>9 sedation, calm him down, and then have a more</p> <p>10 compliant less resistive person to put in that</p> <p>11 position when decreasing the risk of harm to the</p> <p>12 patient, and two it decrease the harm to the</p> <p>13 individual trying to restrain him.</p> <p>14 Q. You know what every authority we have</p> <p>15 says don't leave somebody in a prone position, yet</p> <p>16 you may need to put them down in the prone to</p> <p>17 control them but then get them out; isn't that</p> <p>18 correct?</p> <p>19 A. Every single piece, I don't believe</p> <p>20 that's the case.</p> <p>21 Q. Did you read Sergeant Price's testimony</p> <p>22 his report where he said Troy was trying to turn</p> <p>23 on his side and he, Sergeant Price, held him down</p> <p>24 on his stomach? Did you read that?</p>

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<p style="text-align: right;">222</p> <p>1 A. I don't recall that specifically. I do 2 recall him trying to turn him on his side and he 3 kept spitting back and forth. 4 MR. HUSKISON: This is Berk Huskison and 5 I object to the form of that question. 6 BY MR. EDWARDS: 7 Q. You didn't read that Sergeant Price 8 prevented Troy from turning on his side; yes or 9 no? 10 A. I may have read that. I don't recall 11 the specifics of his commentary on that. 12 Q. Do you know Sergeant Price's size? 13 A. I would have to look that up. I don't 14 know off the top of my head. 15 Q. Six foot five, 285 pounds, does that 16 sound like Sergeant Price? 17 A. I still would have to look that up. 18 Q. Okay. Orange County EMS policy and 19 procedure for patient restraint -- Orange County 20 is what, is that just above you, it's between LA 21 and San Diego, isn't it? 22 A. That is correct. 23 Q. And their EMS policy for patient 24 restraint says that a patient shall be restrained</p>	<p style="text-align: right;">223</p> <p>1 in a supine position or on their side. Are you 2 aware of that? 3 A. I am not. 4 Q. That would be for patient safety, 5 wouldn't it? 6 A. The intent of their protocol I'm not 7 sure why they chose that. 8 Q. Well, all these protocols -- we can 9 agree that the EMS should not be placed in a 10 position of peril; right? 11 A. The EMS should not be placed in a 12 position of peril? 13 Q. Yes. Right. You don't want the EMS to 14 put themselves in a position of peril; right? 15 A. We want them to be safe, sure. 16 Q. So once the patient no longer represents 17 a threat, then you turn your attention to the well 18 being of the patient; correct? 19 A. That's reasonable, sure. 20 Q. What is a recovery position? 21 A. The recovery position has been defined 22 by some as taking somebody in a hobble position 23 and rolling them on their side. 24 Q. You testified to that effect -- did you</p>
<p style="text-align: right;">224</p> <p>1 testify in the Lee versus City of El Monte case? 2 A. That sounds familiar somewhat. I don't 3 know if it's trial or deposition testimony. I 4 can't recall specifically. 5 Q. Have you ever testified in court? 6 A. I have. Yes. 7 Q. How many times? 8 A. Probably about 30 to 40 times maybe. 9 Q. I'm not talking about -- I'm not talking 10 depositions. I'm talking about going into the 11 courtroom? 12 A. Yes. That's what I'm referring to I 13 believe. 14 Q. Is that what you're talking? 15 A. Yes. 16 Q. So 30 to 40 times you have gone into 17 courtrooms throughout the United States in defense 18 of police departments in hogtying cases? 19 A. No. 20 Q. In fairness you said some of the cases 21 in which you participated in has been medical 22 negligent cases? 23 A. Correct. 24 Q. And in those cases you testified on</p>	<p style="text-align: right;">225</p> <p>1 behalf of the hospital? 2 A. Or the plaintiff, depending on the case. 3 Q. Give us the name of a plaintiff where 4 you testified on behalf of? 5 A. I didn't understand -- you muffled your 6 voice the last bit. 7 Q. Give us a reference to a case where you 8 testified on behalf of a plaintiff? 9 A. In deposition or trial or both? 10 Q. Either. 11 A. I'd have to pull my Rule 26 report. It 12 should be in the back there. I don't have the 13 actual cases listed in front of me. 14 Q. Would it have been within the past four 15 years? 16 A. I believe there's some cases in which 17 I've given testimony on a plaintiff's behalf in 18 the last four years. 19 Q. Okay. Were you the director of the San 20 Diego County EMS for 2003 to 2006? 21 A. That's correct. 22 Q. And as the director of the EMS would you 23 have had the responsibility, among other things, 24 of approving all protocols for EMS?</p>

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<p style="text-align: right;">226</p> <p>1 A. That would be part of my role. Yes.</p> <p>2 Q. And so the protocols for the San Diego</p> <p>3 County EMS in effect for 2003 to 2006 would have</p> <p>4 been approved by you?</p> <p>5 A. At some point, yes. They have a</p> <p>6 rotating approval. So if the previous medical</p> <p>7 director put something through and they're not in</p> <p>8 cycle to be reviewed, it could be a period and</p> <p>9 then at some point you generally reviewed them.</p> <p>10 Q. In other words, you put your stamp of</p> <p>11 approval on whatever was put down as a protocol to</p> <p>12 be followed by EMS?</p> <p>13 A. That's what I'm getting at, they rotate</p> <p>14 through certain intervals for review. So if it</p> <p>15 had my stamp on it that would be part of my</p> <p>16 review.</p> <p>17 Q. What is a never event?</p> <p>18 A. A never event at least as I understand</p> <p>19 it is a list of things put out -- I can't remember</p> <p>20 if it's CMS or one of the regulatory bodies about</p> <p>21 things that should never happen. Retain foreign</p> <p>22 objects I think it falls in that category.</p> <p>23 There's a list of things that fall into that,</p> <p>24 that's how they define it.</p>	<p style="text-align: right;">227</p> <p>1 Q. One never event promulgated by CMS is a</p> <p>2 patient should never die in restraints; correct?</p> <p>3 A. That I'd have to look. It sounds like a</p> <p>4 reasonable event. But I don't know if that's the</p> <p>5 reality or not in their list.</p> <p>6 THE WITNESS: This is 50, Bobbie. Pull</p> <p>7 that out please.</p> <p>8 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>9 WAS MARKED AS EXHIBIT NO. 27 TO THE TESTIMONY OF</p> <p>10 THE WITNESS AND IS ATTACHED HERETO.)</p> <p>11 BY MR. EDWARDS:</p> <p>12 Q. Doctor, under Table A, Environment</p> <p>13 Events, death and disability associated with use</p> <p>14 of restraints within facility. You see that?</p> <p>15 A. I'm working on it.</p> <p>16 MR. GASS: Tim, could you please give us</p> <p>17 the title of what you put in front of the Doctor.</p> <p>18 THE WITNESS: I'll say it again. It</p> <p>19 probably comes out clearer for me. It's the CMS</p> <p>20 Center for Medicare and Medicaid Services CMS,</p> <p>21 Center for Medicaid and State Operations July 31,</p> <p>22 2008. Really it says for Center for Medicaid and</p> <p>23 State operations, a letter. It says Dear State</p> <p>24 Medicaid Director is the title of it. It's got a</p>
<p style="text-align: right;">228</p> <p>1 number SMDL No. 08-004.</p> <p>2 MR. GASS: Thank you, Doctor.</p> <p>3 THE WITNESS: It's about five pages.</p> <p>4 BY MR. EDWARDS:</p> <p>5 Q. So a never event is a patient -- a death</p> <p>6 related to a patient in restraints at the</p> <p>7 hospital?</p> <p>8 A. I'm looking for that specifically.</p> <p>9 There you go.</p> <p>10 Q. It's the environmental section, the last</p> <p>11 one.</p> <p>12 A. You're right. It says death/disability</p> <p>13 associated with use of restraints within a</p> <p>14 facility.</p> <p>15 Q. Now, Doctor, I'm trying to sum up here.</p> <p>16 The studies for which you rely to conclude that</p> <p>17 Troy Goode did not die of any asphyxial event were</p> <p>18 all of those studies for which you have been</p> <p>19 involved; is that correct?</p> <p>20 A. And there are other studies that I also</p> <p>21 refer to that I was not involved with that I</p> <p>22 reviewed.</p> <p>23 Q. In all of the studies in which you were</p> <p>24 involved, Troy Goode would not have qualified for</p>	<p style="text-align: right;">229</p> <p>1 participation; correct?</p> <p>2 A. That's not correct, unless you're</p> <p>3 referring to him not being -- I mean, if you're</p> <p>4 talking about as a person who came off the streets</p> <p>5 and wanted to participate in a study not on LSD,</p> <p>6 and acting normal, he could qualify. If you're</p> <p>7 talking about somebody on the side of the road</p> <p>8 going crazy with LSD in his system, then no he</p> <p>9 would not have been able to participate.</p> <p>10 Q. That's what I'm asking you. That's what</p> <p>11 we're dealing with, isn't it, this under the</p> <p>12 influence of LSD?</p> <p>13 A. Well, I didn't understand if you were</p> <p>14 talking about his physiology and background with</p> <p>15 asthma or if you're talking about the LSD</p> <p>16 components, that's why I wanted to clarify.</p> <p>17 Q. With LSD influence or cocaine influence,</p> <p>18 or anything else that somebody might use as a</p> <p>19 recreational drug, those people would not have</p> <p>20 been proper subjects for your studies?</p> <p>21 A. Correct. We could not use somebody who</p> <p>22 is under the influence at the time of the</p> <p>23 research.</p> <p>24 Q. And therefore your studies did not</p>

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<p style="text-align: right;">230</p> <p>1 address people who were in Troy Goode's state at</p> <p>2 the time of his restraint and ultimately death?</p> <p>3 A. They do not involve subjects in the</p> <p>4 state of excited delirium syndrome or under the</p> <p>5 influence of LSD. That part is correct.</p> <p>6 Q. All right, sir. That's also true of</p> <p>7 marijuana? Well, I think we said earlier your</p> <p>8 opinion forthrightly was that marijuana didn't</p> <p>9 play any part in Mr. Goode's demise?</p> <p>10 A. Right. I plan to make no opinion on</p> <p>11 that.</p> <p>12 Q. Well, you've testified in other cases</p> <p>13 that marijuana doesn't cause death, haven't you?</p> <p>14 A. I tend to leave that alone. There are</p> <p>15 some data out there that people think that</p> <p>16 marijuana increase risk of sudden death. I don't</p> <p>17 have enough knowledge based in that area to opine.</p> <p>18 So I just defer any opinion to somebody else who</p> <p>19 may want to.</p> <p>20 Q. Is marijuana legal in your state for any</p> <p>21 purposes?</p> <p>22 A. Is it legal? It is legal for some</p> <p>23 purposes, yes.</p> <p>24 Q. And that's true in 28 other states;</p>	<p style="text-align: right;">231</p> <p>1 correct?</p> <p>2 A. I haven't done the recent math, but it's</p> <p>3 certainly getting to that range.</p> <p>4 Q. Okay. And so, finally, what we have is</p> <p>5 a study by Dr. Stratton, et al, in LA where 18</p> <p>6 people in excited delirium and hobble restrained</p> <p>7 died out of a population of 200, 215, thereabouts;</p> <p>8 correct?</p> <p>9 A. That's about right. Yes.</p> <p>10 Q. And in contrast your stay in Canada in a</p> <p>11 population of almost 500, no person died, no</p> <p>12 person died except one for cocaine toxicity;</p> <p>13 right?</p> <p>14 A. If your definition of the 500 as three</p> <p>15 excited delirium syndrome characteristics or</p> <p>16 greater, than yes. If you're looking at a more</p> <p>17 refined population, it's a smaller group.</p> <p>18 Q. That's fine. If we use the 86 under</p> <p>19 Dr. Stratton's study, eight or nine should have</p> <p>20 died; right?</p> <p>21 A. If the numbers -- if the populations</p> <p>22 were similar, the answer would be that would make</p> <p>23 sense. Yes.</p> <p>24 Q. But the only difference between those 86</p>
<p style="text-align: right;">232</p> <p>1 in Dr. Stratton's studies were nobody in Canada</p> <p>2 was hogtied?</p> <p>3 A. That's not the necessarily only</p> <p>4 difference. Some people in Canada didn't have</p> <p>5 drugs in their system. There were some potential</p> <p>6 epidemiologic characteristic differences. But</p> <p>7 from a physical restraint component, there was no</p> <p>8 nobody hobbled or hogtied up in Canada.</p> <p>9 MR. EDWARDS: That's all I have. Thank</p> <p>10 you, Doctor.</p> <p>11 THE WITNESS: Thank you.</p> <p>12 MR. PHILLIPS: Does anybody on the phone</p> <p>13 have in for Dr. Vilke?</p> <p>14 MR. MACAW: No questions for SEP.</p> <p>15 MR. UPCHURCH: No questions.</p> <p>16 EXAMINATION</p> <p>17 BY MR. HUSKISON:</p> <p>18 Q. This is Berk Huskison on behalf of</p> <p>19 Southaven, I just have one quick question.</p> <p>20 Doctor, looking at your expert report you've got</p> <p>21 several findings, but one of those findings is the</p> <p>22 one I just want to ask you about. You conclude</p> <p>23 that the prone maximal restraint positioning did</p> <p>24 not cause the sudden cardiac arrest and death in</p>	<p style="text-align: right;">233</p> <p>1 Mr. Goode; is that correct? Do you remember that?</p> <p>2 A. I do. Yes.</p> <p>3 Q. And is that opinion to a reasonable</p> <p>4 degree of medical certainty?</p> <p>5 A. Yes, it is.</p> <p>6 MR. HUSKISON: Thank you. That's all I</p> <p>7 have.</p> <p>8 FURTHER EXAMINATION</p> <p>9 BY MR. EDWARDS:</p> <p>10 Q. Doctor, it occurs --</p> <p>11 MR. EDWARDS: I'm sorry, did I cut</p> <p>12 anybody off? No.</p> <p>13 BY MR. EDWARDS:</p> <p>14 Q. I think that it would be -- you did a</p> <p>15 report and a supplemental report; right?</p> <p>16 A. Correct.</p> <p>17 MR. EDWARDS: Bobbie, let's mark both of</p> <p>18 those as separate exhibits, please.</p> <p>19 (WHEREUPON, THE ABOVE-MENTIONED DOCUMENT</p> <p>20 WAS MARKED AS EXHIBIT NO. 28 & 29 TO THE TESTIMONY</p> <p>21 OF THE WITNESS AND IS ATTACHED HERETO.)</p> <p>22 BY MR. EDWARDS:</p> <p>23 Q. Doctor, in one of those, I don't</p> <p>24 remember whether it was the original or the</p>

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<p style="text-align: right;">234</p> <p>1 supplemental, you gave an unsupported opinion that</p> <p>2 there was no requirement of one-on-one observation</p> <p>3 of Mr. Goode. Do you recall that?</p> <p>4 A. Sounds familiar.</p> <p>5 Q. What's the basis for that conclusion?</p> <p>6 A. That agitated individuals in an</p> <p>7 emergency department don't require one-to-one</p> <p>8 observation. They require to be monitored and</p> <p>9 re-evaluated and reassessed. But you don't have</p> <p>10 to have requirement of somebody sitting in the</p> <p>11 room constantly watching that person.</p> <p>12 Q. No, you don't. You can have video,</p> <p>13 can't you?</p> <p>14 A. That is another option to use if you</p> <p>15 want to, sure.</p> <p>16 Q. Yeah. And you can also have remote</p> <p>17 monitoring of the ECG and the pulse oximetry;</p> <p>18 right? You can have that?</p> <p>19 A. Telemetry monitoring is a piece of</p> <p>20 equipment that is available, sure.</p> <p>21 Q. Right. Or you can have somebody who was</p> <p>22 not actually in the room but had a visual on the</p> <p>23 patient?</p> <p>24 A. If you're calling it a one-on-one, they</p>	<p style="text-align: right;">235</p> <p>1 have to have undivided attention. But that's</p> <p>2 another way of doing it, sure.</p> <p>3 Q. So when you say your opinion that he</p> <p>4 didn't need one-on-one observation by a trained</p> <p>5 medical person is what you're referring to; right?</p> <p>6 A. Correct.</p> <p>7 Q. You're not saying that he didn't need</p> <p>8 to -- his pulse oximetry didn't need to be</p> <p>9 monitored, are you?</p> <p>10 A. I'm saying that he needed to be</p> <p>11 monitored visually, and that when with either a</p> <p>12 change in status or when he's more calm to then be</p> <p>13 monitored with the more traditional electronic</p> <p>14 monitoring equipment.</p> <p>15 Q. Okay. So your opinion in your report</p> <p>16 was limited to the one-on-one visual by a trained</p> <p>17 medical person?</p> <p>18 A. Somebody in the room is how most people</p> <p>19 define on one-on-one, like an ICU level nursing</p> <p>20 immediately there.</p> <p>21 Q. Okay. And you've looked at the CMS</p> <p>22 guidelines on that, have you?</p> <p>23 A. I have not looked at the CMS guidelines.</p> <p>24 I was referring to practice in a typical emergency</p>
<p style="text-align: right;">236</p> <p>1 department.</p> <p>2 Q. Well, one second please. Doctor, I do</p> <p>3 have one other question, it just occurred to me,</p> <p>4 I'm sorry. There's so much material here I think</p> <p>5 you can understand it's difficult to cover all the</p> <p>6 basis. But I have one last thing for you. After</p> <p>7 sedation, and I'm talking about in your experience</p> <p>8 since you refer to that a great deal, in your</p> <p>9 hospital people in the excited delirium state who</p> <p>10 have been sedated never died; is that correct?</p> <p>11 A. No. People in excited delirium have</p> <p>12 died.</p> <p>13 Q. I am quoting from your testimony in the</p> <p>14 case of Lee versus Nashville Metropolitan</p> <p>15 Government where you said you have not had any</p> <p>16 patients in excited delirium die after being</p> <p>17 sedated; true or not?</p> <p>18 A. I have personally had somebody die in</p> <p>19 the process of trying to get them sedated but not</p> <p>20 once they become sedate, no. That would be a true</p> <p>21 statement.</p> <p>22 Q. Okay. So you're talking about somebody</p> <p>23 dying while you're in the process of administering</p> <p>24 the sedative?</p>	<p style="text-align: right;">237</p> <p>1 A. Correct. Before they become sedate.</p> <p>2 Q. But thereafter, you haven't had anyone</p> <p>3 pass away?</p> <p>4 A. Knock on wood, yeah. Correct.</p> <p>5 Q. Have you had any deaths due to prone</p> <p>6 positioning in your hospital?</p> <p>7 A. To prone positioning at my hospital? I</p> <p>8 don't know the totality of cases at my hospital.</p> <p>9 So I guess it's possible that something have</p> <p>10 happened that somebody died while being in a prone</p> <p>11 position, OR or something like that. But I don't</p> <p>12 know the answer to that.</p> <p>13 Q. Let me ask it a different way. I said</p> <p>14 due to prone positioning. Have you as -- have you</p> <p>15 had a patient that died while in a prone position</p> <p>16 in your care?</p> <p>17 A. I don't think so. I mean, certainly not</p> <p>18 an agitated or sedated person that way. I'm just</p> <p>19 trying to think of anybody I had to be on their</p> <p>20 stomach for any particular procedure in the ED</p> <p>21 that might have died. And I can't off the top of</p> <p>22 my head come up with something. The best answer I</p> <p>23 can come up with is I don't recall any. No.</p> <p>24 Q. All right. Have you ever had the</p>

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<p style="text-align: right;">238</p> <p>1 occasion to report to CMS on death of a patient in 2 restraints?</p> <p>3 A. Have I personally? No. Not -- again, 4 not that I recall from my career that happening, 5 no. Has any been reported from our hospital, it's 6 possible. But I'm not aware of it.</p> <p>7 Q. Are you aware of the requirement under 8 the Code of Federal Regulations that death in 9 restraints be reported to CMS?</p> <p>10 A. It's I believe on one of the lists of 11 the things that they have to have to be reported. 12 I'm familiar with the list. I think that is on 13 there.</p> <p>14 Q. Whether they are in law enforcement 15 restraints or hospital restraints it has to be 16 reported; correct?</p> <p>17 A. That's what where I think the language 18 does not specify. So I would defer to regulatory 19 to make that decision if that needs to be reported 20 or not.</p> <p>21 Q. Have you ever received any CMS, you or 22 your hospital received any CMS warning letters 23 about operational difficulties?</p> <p>24 A. I have not received any letters from</p>	<p style="text-align: right;">239</p> <p>1 CMS. I would not necessarily know what my 2 hospital has received because all those types of 3 things are determined usually through regulatory 4 and administration. So I am not thinking off the 5 top of my head of anything that I'm aware of. 6 Could there have been an e-mail that came out from 7 a chief medical officer at some point in the past 8 about something, it's certainly possible. But I'm 9 not recalling anything off the top of my head.</p> <p>10 MR. EDWARDS: Thank you, Doctor.</p> <p>11 THE WITNESS: Thank you.</p> <p>12 THE VIDEOGRAPHER: We're going off the 13 record. This concludes the videotaped deposition 14 media number four. The time is 1:37 p.m.</p> <p>15 16 17 18 19 20 21 22 23 24</p>
<p style="text-align: right;">240</p> <p>1 C E R T I F I C A T E 2 STATE OF TENNESSEE) 3) 4 COUNTY OF SHELBY)</p> <p>5 I, BOBBIE HIBBLER, LCR #029, CSR, Licensed 6 Court Reporter, in and for the State of Tennessee, 7 do hereby certify that the above deposition was 8 reported by me, and the transcript is a true and 9 accurate record to the best of my knowledge, 10 skills, and ability.</p> <p>11 I further certify that I am not related to 12 nor an employee of counsel or any of the parties 13 to the action, nor am I in any way financially 14 interested in the outcome of this case.</p> <p>15 I further certify that I am duly licensed 16 by the Tennessee Board of Court Reporting as a 17 Licensed Court Reporter as evidenced by the LCR 18 number and expiration date following my name 19 below.</p> <p>20 I further certify that this transcript is 21 the work product of this court reporting agency 22 and any unauthorized reproduction and/or transfer 23 of it will be in violation of Tennessee Code 24 Annotated 39-14-104, Theft of Services.</p> <p style="text-align: center;">BOBBIE HIBBLER, LCR #029 Expiration Date 07-01-2018</p>	

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